Application for a §1915(c) Home and Community-Based Services Waiver

PURPOSE OF THE HCBS WAIVER PROGRAM

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in §1915(c) of the Social Security Act. The program permits a State to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The State has broad discretion to design its waiver program to address the needs of the waiver's target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid State plan and other federal, state and local public programs as well as the supports that families and communities provide.

The Centers for Medicare & Medicaid Services (CMS) recognizes that the design and operational features of a waiver program will vary depending on the specific needs of the target population, the resources available to the State, service delivery system structure, State goals and objectives, and other factors. A State has the latitude to design a waiver program that is cost-effective and employs a variety of service delivery approaches, including participant direction of services.

Request for an Amendment to a §1915(c) Home and Community-Based Services Waiver

1. Request Information

A. The **State** of **Wyoming** requests approval for an amendment to the following Medicaid home and community-based services waiver approved under authority of §1915(c) of the Social Security Act.

B. Program Title:
Acquired Brain Injury Waiver

C. Waiver Number:WY.0370
Original Base Waiver Number: WY.0370.

D. Amendment Number:

E. Proposed Effective Date: *(mm/dd/yy)*
07/01/16

Approved Effective Date of Waiver being Amended: 07/01/14

2. Purpose(s) of Amendment

Purpose(s) of the Amendment. Describe the purpose(s) of the amendment:

Proposed Changes (Across the Comprehensive, Supports, and ABI Waivers) It has been requested that these rates be retroactive to July 1, 2016.
1) Rate Increase: The Behavioral Health Division (BHD) proposes an across the board rate increase of 3.3% and an accompanying 3.3% increase to Individual Budget Amounts (IBA).
2) The Department of Labor (DOL) promulgated rule (78 FR 60454-85) addresses definition changes in the Fair Labor Standard Act, 29 U.S.C. § 201 et seq. that affect a governmental unit's status as an employer. As a result, it prohibits employers other than the individual or their families or households from claiming the companionship services exemption from overtime. Three services have been identified which required additional rate increases to meet DOL overtime requirements. These rate increases replace the 3.3% increase for the specified services.

3. Nature of the Amendment

A. Component(s) of the Approved Waiver Affected by the Amendment. This amendment affects the following component(s) of the approved waiver. Revisions to the affected subsection(s) of these component(s) are being submitted concurrently *(check each that applies):*

Component of the Approved Waiver	Subsection(s)
☐ Waiver Application	
☐ Appendix A – Waiver Administration and Operation	
☐ Appendix B – Participant Access and Eligibility	
☐ Appendix C – Participant Services	
☐ Appendix D – Participant Centered Service Planning and Delivery	
☐ Appendix E – Participant Direction of Services	
☐ Appendix F – Participant Rights	
☐ Appendix G – Participant Safeguards	
☐ Appendix H	
☐ Appendix I – Financial Accountability	
☑ Appendix J – Cost-Neutrality Demonstration	2

B. Nature of the Amendment. Indicate the nature of the changes to the waiver that are proposed in the amendment *(check each that applies):*

- ☐ **Modify target group(s)**
- ☐ **Modify Medicaid eligibility**
- ☐ **Add/delete services**
- ☐ **Revise service specifications**

- [ ] **Revise provider qualifications**
- [ ] **Increase/decrease number of participants**
- [x] **Revise cost neutrality demonstration**
- [ ] **Add participant-direction of services**
- [ ] **Other**

Specify:

Application for a §1915(c) Home and Community-Based Services Waiver

1. Request Information (1 of 3)

A. The **State** of **Wyoming** requests approval for a Medicaid home and community-based services (HCBS) waiver under the authority of §1915(c) of the Social Security Act (the Act).

B. Program Title (*optional - this title will be used to locate this waiver in the finder*):

Acquired Brain Injury Waiver

C. Type of Request: amendment

Requested Approval Period:*(For new waivers requesting five year approval periods, the waiver must serve individuals who are dually eligible for Medicaid and Medicare.)*

○ **3 years** ◉ **5 years**

Original Base Waiver Number: WY.0370
Draft ID: WY.006.03.02

D. Type of Waiver *(select only one):*

Regular Waiver

E. Proposed Effective Date of Waiver being Amended: 07/01/14
Approved Effective Date of Waiver being Amended: 07/01/14

1. Request Information (2 of 3)

F. Level(s) of Care. This waiver is requested in order to provide home and community-based waiver services to individuals who, but for the provision of such services, would require the following level(s) of care, the costs of which would be reimbursed under the approved Medicaid State plan (*check each that applies*):

- [ ] **Hospital**

Select applicable level of care

- ○ **Hospital as defined in 42 CFR §440.10**

If applicable, specify whether the State additionally limits the waiver to subcategories of the hospital level of care:

- ○ **Inpatient psychiatric facility for individuals age 21 and under as provided in42 CFR §440.160**

- [ ] **Nursing Facility**

Select applicable level of care

- ○ **Nursing Facility as defined in 42 CFR ◆◆440.40 and 42 CFR ◆◆440.155**

If applicable, specify whether the State additionally limits the waiver to subcategories of the nursing facility level of care:

- ○ **Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140**

- [x] **Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR §440.150)**

If applicable, specify whether the State additionally limits the waiver to subcategories of the ICF/IID level of care:

1. Request Information (3 of 3)

G. Concurrent Operation with Other Programs. This waiver operates concurrently with another program (or programs) approved under the following authorities

Select one:

- ◉ **Not applicable**
- ○ **Applicable**

Check the applicable authority or authorities:

- [ ] **Services furnished under the provisions of §1915(a)(1)(a) of the Act and described in Appendix I**

☐ **Waiver(s) authorized under §1915(b) of the Act.**

Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:

Specify the §1915(b) authorities under which this program operates *(check each that applies):*

- ☐ **§1915(b)(1) (mandated enrollment to managed care)**
- ☐ **§1915(b)(2) (central broker)**
- ☐ **§1915(b)(3) (employ cost savings to furnish additional services)**
- ☐ **§1915(b)(4) (selective contracting/limit number of providers)**

☐ **A program operated under §1932(a) of the Act.**

Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment has been submitted or previously approved:

☐ **A program authorized under §1915(i) of the Act.**

☐ **A program authorized under §1915(j) of the Act.**

☐ **A program authorized under §1115 of the Act.**

Specify the program:

H. Dual Eligiblity for Medicaid and Medicare.

Check if applicable:

☑ **This waiver provides services for individuals who are eligible for both Medicare and Medicaid.**

2. Brief Waiver Description

Brief Waiver Description. *In one page or less*, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.

In March 2013, the Wyoming Legislature passed Senate Enrolled Act 0082 requiring the Wyoming Department of Health, Behavioral Health Division (the Division) to develop redesigned waivers for people with DD and for people with Acquired Brain Injuries which had new redesigned funding methodologies and more residential and day service options. The redesigned ABI Waiver will provide a wide array of services and flexibility to meet an individual's needs and to promote and support independence; develop some new supported living and residential service options, increase employment support and career development options; and focus on outcomes for people served.

The ABI Waiver represents Wyoming's commitment to funding supportive and comprehensive services to eligible participants with acquired brain injuries from ages 21 through the life span, so they can actively participate in the community with friends and family, be competitively employed, and live as healthy, safe, and independently as possible according to their own choices and preferences. The ABI Waiver uses a person-centered approach to determine the support needs of participants in the Individual Plan of Care and to assign the individual budgeted amount. Developing community and natural supports and connections and supporting self-direction are essential components of the ABI Waiver, but traditional service delivery is also available to participants on the ABI Waiver.

Purpose
The Acquired Brain Injury (ABI) Waiver program serves adults ages 21 and older with qualified brain injuries and deemed eligible, so they can strive to live healthy, safely, and as independently as possible, and receive individualized support in reintegrating with the friends, family and job skills they had prior to the brain injury.

Goals
The ABI Waiver goals are to:
1) provide an alternative to institutional services;
2) increase one's independence and quality of life by having outcome-based services, including more employment services;
3) increase flexibility of service planning and delivery to meet an individual's needs;
4) provide the opportunity for all participants self-direct their services to the extent that they choose;
5) ensure the health, safety and welfare of waiver participants;
6) encourage relationship-based services; and
7) identify, monitor and evaluate outcomes for eligible participants.

Objectives
Referring to the goals listed above, the waiver objectives are to:
1) provide an updated menu of services, including a continuum of residential and employment support to serve participants in the least restrictive and most appropriate environment;
2) provide participants increased opportunities for community involvement;
3) offer the opportunity for self-direction all waiver participants;
4) set and achieve targeted outcomes for each participant served; and
5) monitor and enhance continuous improvement strategies to improve service delivery for participants.

Organizational Structure
The ABI Waiver is administered through the Single State Medicaid Agency (SMA), under the Wyoming Department of Health, Behavioral Health Division (referred to as the "BHD or The Division" in this application. The State Medicaid Agent maintains administrative authority over the BHD Waivers and oversees the BHD performance of operational functions. BHD performs the statewide waivers operational and daily administrative functions, the application and eligibility process, prior authorization of all services, utilization management, crisis resolution, critical incident reporting, complaint investigation, and quality management.

Service Delivery Methods
The ABI Waiver provides participants and their families the opportunity for enhanced health, freedom, choice, control, and responsibility over services received through the statewide availability of self-directed service delivery. Waiver participants may also opt for traditional service delivery or a mix of the two.

Quality Management
Wyoming's Quality Management Strategy, is a continuous improvement model that includes tracking the efficiency and effectiveness of our operations, system, service offerings and supports in achieving the desired outcomes for participants. This Quality Management Strategy includes discovery, planning, monitoring, implementation and evaluation of our processes to determine whether the waiver operates in accordance with the program's quality design, to assure the health and welfare of participants, and to identify opportunities for continuous improvement.

3. Components of the Waiver Request

The waiver application consists of the following components. *Note: Item 3-E must be completed.*

A. Waiver Administration and Operation. Appendix A specifies the administrative and operational structure of this waiver.

B. Participant Access and Eligibility. Appendix B specifies the target group(s) of individuals who are served in this waiver, the number of participants that the State expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.

C. Participant Services. Appendix C specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.

D. Participant-Centered Service Planning and Delivery. Appendix D specifies the procedures and methods that the State uses to develop, implement and monitor the participant-centered service plan (of care).

E. Participant-Direction of Services. When the State provides for participant direction of services, **Appendix E** specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. (*Select one*):

- (●) **Yes. This waiver provides participant direction opportunities.** *Appendix E is required.*
- ( ) **No. This waiver does not provide participant direction opportunities.** *Appendix E is not required.*

F. Participant Rights. Appendix F specifies how the State informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.

G. Participant Safeguards. Appendix G describes the safeguards that the State has established to assure the health and welfare of waiver participants in specified areas.

H. Quality Improvement Strategy. Appendix H contains the Quality Improvement Strategy for this waiver.

I. Financial Accountability. Appendix I describes the methods by which the State makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.

J. Cost-Neutrality Demonstration. Appendix J contains the State's demonstration that the waiver is cost-neutral.

4. Waiver(s) Requested

A. Comparability. The State requests a waiver of the requirements contained in §1902(a)(10)(B) of the Act in order to provide the services specified in **Appendix C** that are not otherwise available under the approved Medicaid State plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in **Appendix B**.

B. Income and Resources for the Medically Needy. Indicate whether the State requests a waiver of §1902(a)(10)(C)(i)(III) of the Act in order to use institutional income and resource rules for the medically needy *(select one)*:

- ( ) **Not Applicable**
- (•) **No**
- ( ) **Yes**

C. Statewideness. Indicate whether the State requests a waiver of the statewideness requirements in §1902(a)(1) of the Act *(select one)*:

- (•) **No**
- ( ) **Yes**

If yes, specify the waiver of statewideness that is requested *(check each that applies)*:

☐ **Geographic Limitation.** A waiver of statewideness is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the State.

Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:

☐ **Limited Implementation of Participant-Direction.** A waiver of statewideness is requested in order to make *participant-direction of services* as specified in **Appendix E** available only to individuals who reside in the following geographic areas or political subdivisions of the State. Participants who reside in these areas may elect to direct their services as provided by the State or receive comparable services through the service delivery methods that are in effect elsewhere in the State.

Specify the areas of the State affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:

5. Assurances

In accordance with 42 CFR §441.302, the State provides the following assurances to CMS:

A. Health & Welfare: The State assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:

1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;

2. Assurance that the standards of any State licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The State assures that these requirements are met on the date that the services are furnished; and,

3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable State standards for board and care facilities as specified in **Appendix C**.

B. Financial Accountability. The State assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.

C. Evaluation of Need: The State assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community-based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.

D. Choice of Alternatives: The State assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:

1. Informed of any feasible alternatives under the waiver; and,

2. Given the choice of either institutional or home and community-based waiver services. **Appendix B** specifies the procedures that the State employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.

E. Average Per Capita Expenditures: The State assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid State plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.

F. Actual Total Expenditures: The State assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the State's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.

G. Institutionalization Absent Waiver: The State assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.

H. Reporting: The State assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid State plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.

I. Habilitation Services. The State assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.

J. Services for Individuals with Chronic Mental Illness. The State assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the State has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) age 21 and under and the State has not included the optional Medicaid benefit cited in 42 CFR § 440.160.

6. Additional Requirements

Note: Item 6-I must be completed.

A. Service Plan. In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including State plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.

B. Inpatients. In accordance with 42 CFR §441.301(b)(1)(ii), waiver services are not furnished to individuals who are in-patients of a hospital, nursing facility or ICF/IID.

C. Room and Board. In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the State that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.

D. Access to Services. The State does not limit or restrict participant access to waiver services except as provided in **Appendix C**.

E. Free Choice of Provider. In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the State has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.

F. FFP Limitation. In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.

G. Fair Hearing: The State provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the State's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.

H. Quality Improvement. The State operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the State assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The State further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the State will implement the Quality Improvement Strategy specified in **Appendix H**.

I. Public Input. Describe how the State secures public input into the development of the waiver:

Public Input for the March 2014 submission of the waiver:

The first public notice on the full waiver was sent out in February 2014. Notice went out on the Division's listserv and in ads in the two main newspapers in Wyoming. Tribal Notification went out to the tribes in February too. The notices included the website to find the full waiver application and how to submit comments. During the Division's monthly provider support call, we discussed the changes to the ABI waiver in the renewal. Forums were held in conjunction with other waiver changes around the state in 2013. Summary of public comment is at the bottom of this section. A second public notice went out with the transition plan in May and September 2014. The Sept 2014 notice also went out in a newsletter to all participants and guardians telling them where to access the information on the waivers and transition plans for the state and how to contact us to give input or ask questions.

For the ABI waiver renewal, BHD used frequent and transparent communication and training to the public. We had nearly 20 teams with different work projects and leadership levels involved. Internal member teams still meet on this waiver. External stakeholders are involved in the transition planning team.

Redesign Vision
The teams initially discussed the vision they had for the waivers in 5, 10, and 20 years. The Stakeholder Committee that included people representing the ABI population, developed a dynamic vision, which was shared with all other team members. They want the ABI waivers to lead to more independence for the people served, supports to be truly person-centered, to incorporate relationship-based services, and be flexible and outcomes-based. The Core team and Leadership team visions mirror these ideas and the teams are using these guiding principles to ensure the changes and improvements made to the waivers align with the legislation and their vision. The stakeholder committee that currently meets is focused on the HCB Settings transition plan and will reconvene with new stakeholder members for a waiver input/design team upon completion of the approved HCB transition plan.

Project websites were developed to keep people informed. The first is internal for State staff and the other is on the Division's public website: http://health.wyo.gov/ddd/index.html, which contained a recording of the forum presentation, links to news articles, the legislation, an online survey, and FAQs about the redesign.

Community Forums
BHD partnered with the Wyoming Governor's Council on DD to hold 11 community forums around the state to inform participants and families about the legislation and the plan for changes, gather input on their ideas for improvements to the waivers, hear their fears and concerns, and answer their questions. The forum schedule was posted in newspaper advertisements around the state and sent out on listserv e-mails to providers and legislators. A paper mailing with the schedule, project website, and survey information was sent to all active waiver participants, guardians, and people on the waiting lists. Attendance to the forums has totaled 780 people, including Jackson – 64, Cody – 43, Evanston – 138, Cheyenne – 200, Mountain View – 40, Riverton – 40, Casper – 92, Rock Springs-45, Casper (2nd forum)-27, Gillette-44, and Sheridan-47.

Provider Training and Input
BHD requested two national experts in this field, Nancy Thaler and Robin Cooper from NASDDDS, to assist us in having a separate presentation and discussion with providers on the waiver changes. The provider forum held April 23, 2013 in Cheyenne brought 117 providers and 20 WDH staff together to learn about the changes that are coming and the importance in making these systems changes. This training was held again on May 20, 2013 by teleconference and webinar with over 100 people participating.

Survey for Public Input
BHD created a survey to gather feedback from the public and stakeholders on DD and ABI waiver services and preferences that can be used to help redesign the waivers as required by Senate Enrolled Act 0082. There were a total of 484 surveys submitted to the website as of May 31, 2013, and 38 were specific to ABI participants or ABI folks on the wait list, and 30 that were for all the populations. All survey input was coded by topics and questions in order to query information on specific topics or by specific categories of respondents. The survey consisted of 7 questions.

Responses during public comment
10 responses submitted wanting options besides day habilitation or to have an increase in supported living than more residential services.
State response: We added several new services to the waiver to offer more day service alternatives. The increase in supported living cannot occur until the rates are rebased in 2015.

There were also requests from five people to increase the use of resources from other state agencies to meet a person's needs.
State: We have a goal to collaborate closely with other agencies to better coordinate services and provide wraparound approach to help meet people's needs.

Regarding the IBA methodology change, ten people voiced concerns with the budgets changing too much, but others felt that there should be a shift to fund in a way that promotes more supported living over residential services.
State: We will implement the new budget methodology on new people and hold current participants at their current budget, since the plan is to end the ABI waiver and transition all participants to the Comprehensive waiver in the near future.

Ten people were curious about wait list funding and having services quicker.
State: The waiver redesign involves adjusting the funding methodology for new people and should decrease the time for people on the wait list.

J. Notice to Tribal Governments. The State assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State of the State's intent to submit a Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date is provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.

K. Limited English Proficient Persons. The State assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003). **Appendix B** describes how the State assures meaningful access to waiver services by Limited English Proficient persons.

7. Contact Person(s)

A. The Medicaid agency representative with whom CMS should communicate regarding the waiver is:

Last Name: Green

First Name: Teri

Title:

State Medicaid Agent

Agency: Division of Healthcare Financing - State Medicaid Agency

Address: 6101 Yellowstone Road, Suite 210

Address 2:

City: Cheyenne

State: **Wyoming**

Zip: 82002

Phone: (307) 777-7908 **Ext:** **TTY**

Fax: (307) 777-6964

E-mail: teri.green@wyo.gov

B. If applicable, the State operating agency representative with whom CMS should communicate regarding the waiver is:

Last Name: Pratt

First Name: Shirley

Title: Policy Analyst

Agency: Behavioral Health Division

Address: 6101 Yellowstone Rd Ste 220

Address 2:

City: Cheyenne

State: **Wyoming**

Zip: 82002

Phone: (307) 777-2525 **Ext:** **TTY**

Fax: (307) 777-6047

E-mail: shirley.pratt@wyo.gov

8. Authorizing Signature

This document, together with the attached revisions to the affected components of the waiver, constitutes the State's request to amend its approved waiver under §1915(c) of the Social Security Act. The State affirms that it will abide by all provisions of the waiver, including the provisions of this amendment when approved by CMS. The State further attests that it will continuously operate the waiver in accordance with the assurances specified in Section V and the additional requirements specified in Section VI of the approved waiver. The State certifies that additional proposed revisions to the waiver request will be submitted by the Medicaid agency in the form of additional waiver amendments.

Signature:

State Medicaid Director or Designee

Submission Date:

Note: The Signature and Submission Date fields will be automatically completed when the State Medicaid Director submits the application.

Last Name: Green

First Name: Teri

Title: State Medicaid Agent

Agency: Division of Healthcare Financing- State Medicaid Agency

Address: 6101 Yellowstone Road, Suite 210

Address 2:

City: Cheyenne

State: **Wyoming**

Zip: 82002

Phone: (307) 777-7908 **Ext:** **TTY**

Fax: (307) 777-6964

E-mail: teri.green@wyo.gov

Attachments

Attachment #1: Transition Plan

Check the box next to any of the following changes from the current approved waiver. Check all boxes that apply.

- **Replacing an approved waiver with this waiver.**
- **Combining waivers.**
- **Splitting one waiver into two waivers.**
- **Eliminating a service.**
- **Adding or decreasing an individual cost limit pertaining to eligibility.**
- **Adding or decreasing limits to a service or a set of services, as specified in Appendix C.**
- **Reducing the unduplicated count of participants (Factor C).**
- **Adding new, or decreasing, a limitation on the number of participants served at any point in time.**
- **Making any changes that could result in some participants losing eligibility or being transferred to another waiver under 1915(c) or another Medicaid authority.**
- **Making any changes that could result in reduced services to participants.**

Specify the transition plan for the waiver:

Service Changes
Waiver includes six new services: Behavioral Support Services, Employment Discovery and Customization, Prevocational, Supported Employment Follow Along, Transportation and Adult Day Services.

Services not included on the new waivers are Agency with Choice and Unpaid Caregiver Training, which are currently on the ABI waiver. Unpaid Caregiver Training has not been utilized by any waiver participants, so no participants will need to transition. Agency with Choice is not utilized by any ABI participants, so no transition is needed. All ABI participants will be notified that the two services are no longer available and that six new services are available to them.

Day Habilitation is now called Community Integration Services and has a community Integration requirement in the definition. The service is changing to a 15 minute unit and the daily unit is being phased out over the first year as plans come due on their annual cycle. Some participants may choose the new Adult Day service instead of the Community Integration Service depending on their functioning level.

Day Hab and Res Hab Intervention services is becoming "Crisis Intervention Services" and will be a service that can only be used in conjunction with Res Hab, Community Integration, or Prevocational Services. The definition of the service has changed and used to be included in the Res Hab and Day Hab service definition on the old waiver application. It is now listed separately.

Minimizing the impact
A BHD transition team is in place to address all of the major moving pieces in order to minimize the impact of the changes on current waiver participants and assure the health and welfare of affected individuals who may be losing some services they are currently receiving.

Implementing a new assessment and IBA methodology
In order to implement the new IBA methodology for any new waiver participant, an eligible person for the wait list who receives a funding letter for the ABI waiver will be assessed based upon their ICAP assessment. IBAs will be generated based upon the information collected in the ICAP and entered into the database. A budget will be assigned based on the person's Level of Service need and their prior plan of care and service utilization. The Budget Review process will allow participants and teams to request a review of the assigned IBA and present additional case information if they do not agree with the level of service need. Once people's budgets are established they will not change year to year. This means budgets will not be reduced if the full amount is not used in a year. If there is a significant change in a person's support needs due to emergency situations or a significant change in health, the case manager may submit a request for additional funding through ECC, which is the process currently utilized. No one will lose eligibility as a result of their budget being higher than the new cost limit for the waiver.

BHD is monitoring the IBA methodology change using a continuous improvement model, where we will study the effectiveness quarterly after implementation and decide if adjustments are needed, if the process to review requests is timely, and design updates or changes when warranted.

Completing a Representative Sample of Case Reviews
With the new regulations by CMS to allow states to combine waiver populations for the sample size, BHD will use a stratified sample. Due to the transition timeline in 2014, the representative sample of case reviews for the current ABI waiver, Adult DD and Child DD waivers,and new Supports and Comprehensive waivers will be reflected in the sample pulled for the new waivers. Case reviews completed will apply for both waivers for which the person is served during the two-year cycle beginning July 2013.

Right to a Fair Hearing
BHD will follow the Wyo Medicaid rules for offering a right to a fair hearing for any adverse action taken, including: (a) not providing an individual the choice of home and community-based services as an alternative to institutional care; (b) denying an individual the service(s) of their choice or the provider(s) of their choice; and, (c) actions to deny, suspend, reduce or terminate services. Notification shall be given in writing to the participant or guardian. With the notification, BHD will also explain alternative dispute resolution procedures the participant and team can follow to appeal the decisions that adversely affect their choice in services or providers, including the process to file a reconsideration, a complaint, or grievance.

Attachment #2: Home and Community-Based Settings Waiver Transition Plan
Specify the state's process to bring this waiver into compliance with federal home and community-based (HCB) settings requirements at 42 CFR 441.301(c)(4)-(5), and associated CMS guidance.
Consult with CMS for instructions before completing this item. This field describes the status of a transition process at the point in time of submission. Relevant information in the planning phase will differ from information required to describe attainment of milestones.
To the extent that the state has submitted a statewide HCB settings transition plan to CMS, the description in this field may reference that statewide plan. The narrative in this field must include enough information to demonstrate that this waiver complies with federal HCB settings requirements, including the compliance and transition requirements at 42 CFR 441.301(c)(6), and that this submission is consistent with the portions of the statewide HCB settings transition plan that are germane to this waiver. Quote or summarize germane portions of the statewide HCB settings transition plan as required.
Note that Appendix C-5 HCB Settings describes settings that do not require transition; the settings listed there meet federal HCB setting requirements as of the date of submission. Do not duplicate that information here.
Update this field and Appendix C-5 when submitting a renewal or amendment to this waiver for other purposes. It is not necessary for the state to amend the waiver solely for the purpose of updating this field and Appendix C-5. At the end of the state's HCB settings transition process for this waiver, when all waiver settings meet federal HCB setting requirements, enter "Completed" in this field, and include in Section C-5 the information on all HCB settings in the waiver.

PUBLIC COMMENT
Transition plan first posted for Public Comment on April 20, 2014 until May 20, 2014. Then again for 30 days for tribal notification. Upon feedback from CMS, the transition plan was posted for public comment again on October 3, 2014 with more details. Public comment on the transition plan was taken from October 3, 2014 through November 3, 2014 and was posted in the ABI waiver renewal document and posted separately on the Division's website. Ads with public comment information ran in largest Wyoming papers and a listserv announcement to providers and stakeholders each time. A summary of the plan was posted on the Division's website for comment and a draft of the waiver renewal with the plan was posted to the Division's website during the comment period. The public was invited to submit comments through an email address (bhdmail@wyo.gov) and forums were held at six locations across the state (Laramie, Cheyenne, Jackson, Evanston, Sheridan and Casper). A presentation on the state's transition plans was conducted at this year's Mega Conference and a recording was posted using YouTube, and the link was on the Division's website for people who cannot attend in person. Two conference calls were held for people during the 30 day period, so they could call in with their comments. A newsletter with information on the ABI waiver Transition Plan was send to all waiver participants and guardians, and it included the Division's website where the transition plan and waiver application was available, the Division's email address, phone number, and address to contact us, submit public comment or ask for copies. It also included the public forum schedule and the conference call number for those who could not make it in person. The newsletter was sent out to nearly 2,000 people on the Division's listserv. The transition taskforce, which has members from various roles within the waiver system, reviewed and discussed input collected to help make final changes to the Transition plan.

A thorough summary of all comments and the state's responses was sent via email to CMS.

OVERVIEW
On March 17, 2014, the Centers for Medicaid and Medicare Services (CMS) promulgated new federal regulations that set new standards for Home and Community Based Service (HCBS) Settings. The new standards require the state to have all HCB Settings come into compliance within 5 years of March 17, 2014. The federal regulations are 42 CFR 441.301(c)(4)-(5). CMS posted additional guidance to help states assess compliance and remediate areas that are not fully incompliance. More information on the rules can be found on the CMS website at www.medicaid.gov/hcbs. The new requirements address standards for informed choice, protecting the rights of participants, requiring settings to be integrated, not isolating to participants, and not institutional in nature or in its characteristics. To adhere to these rules, each state must submit a transition plan to assess the current settings and implement remediation with the areas of non-compliance within a 5-year timeline.

CHANGES TO THE TRANSITION PLAN DUE TO PUBLIC COMMENT
Public comments overwhelmingly recommended that the Division focus on assuring services are supporting people to be integrated in the community instead of focusing on the location where services are delivered. From the initial provider survey, settings were flagged for concern due to location issues such as industrial or commercial zoning areas or a rural area. After more analysis, the state decided these flags were an unfair assumption. They are now considered an "indicator" of possible segregation or isolation where the state needs more information to ensure the person's in those settings have services provided in compliance with the new rules. The flags were removed because providers and family made the case that the zoning characteristic was not an accurate indicator of segregation or isolation and not all industrial zones are created equal in a city. Some locations in these zones are close to other businesses that are safely and regularly visited. Some zones are further from businesses that can be frequented. Providers and family members in these locations mentioned that they still get to access the community and get out more often than other family members living at the family home, so if a provider can provide regular access to the community, the provider setting should not be eliminated from HCB by location alone. Additionally, towns and cities can change the zoning of different areas quickly and easily, but that zones are not always updated to ensure that they reflect the characteristics of an area. This renders the method of enforcing the new rules ineffective, because a provider would only need to their building's zoning changed. The Department of Health's leadership team agreed to make these changes and said that we would not disqualify a setting based on this characteristic alone. In our additional analysis in 2015, providers of settings that may appear to isolate or segregate, or are located on or adjacent to an institution, must give evidence on how people access the community, how often, and what they do so we can help them improve in this area or make modifications to their business model to meet the integration standards. Moreover, many people like to live in Wyoming due to its rural nature. Therefore, for residences that are not near other residences or near a community with businesses, the setting cannot be ruled as non-HCB by location alone. The provider must still provide evidence to the state on how they help the person access the community, provide transportation, and integrate the person (as well as the other standards in the new rule.)

Also, the non-residential settings that appear to segregate people with disabilities from the general public will not be disqualified from being considered HCB on this fact alone; the setting will be evaluated for other characteristics and individual experiences before being considered non-HCB.
Rather than requiring specific milestones each year, providers will be issued a report of areas of non-compliance and will complete a transition plan with milestones and timelines each year. They will have the rest of the five years to come into compliance with the standards but must make progress each year. State monitoring processes will oversee the provider's compliance to their own transition plans.

PRELIMINARY RESULTS
ABI waiver participants live in family homes, independently, semi-independently and receive supported living, and in residential group homes, host homes, or apartments. 333 Settings were evaluated for the ABI and DD populations, in which 43 settings serve people with ABI (107 ABI participants total.) 0 are in compliance and 43 are not in compliance, but with modifications they should be in compliance at the end of five year transition timeline. The areas on non-compliance are mostly related to access to food, ability to have an unregimented day, lack of integration in the settings, and having a signed lease or key. All areas that can be modified to come into compliance.

Further analysis of the settings through stakeholder surveys, onsite visits, case management reports, and participant and guardian interviews will be conducted during 2015 and 2016 to ensure that any setting with areas of non-compliance will be addressed by providers. No settings have been determined at this time to be non-HCB at this time and subject to heightened scrutiny by CMS.

TRANSITION TIMELINE AND MILESTONES
The following action plan shows how the state Medicaid agency will ascertain that all waiver settings meet federal requirements now and within the timeline allowed under the new HCB Setting regulations.

Year 1 - Milestones for March 17, 2014 and March 16, 2015

1. Milestone: By June 2014 and ongoing until 2016, a Transition Stakeholder team has been established and meets monthly. This stakeholder team that represents a cross section of the waiver providers, participants, and agency staff will meet to discuss and set standards and complete self-assessments for Wyoming and help with ongoing issues.
Action items:
- Request members & charter team expectations
- Meet regularly, monthly if possible
- Have members from multiple levels within the waiver systems, advocacy groups, participants, guardians, providers and have various parts of the state represented.

2. Milestone: Starting in November 2014, the state will inventory provider settings and conduct an assessment of compliance with HCB standards in federal rules. Settings must be evaluated to see if they meet the standards and are required to fix the areas of non-compliance in order to remain HCB providers according to the state's approved transition plan. Settings will be considered one of the following:
a) In Compliance (fully align with the Federal requirements)
b) Does not comply with the Federal requirements and will require modifications
c) Cannot meet the Federal requirements and require removal from the program and/or the relocation of individuals
d) Presumptively non-home and community-based but for which the state will provide justification / evidence to show that those settings do not have the characteristics of an institution and do have the qualities of HCBS (to be evaluated by CMS through heightened scrutiny process
Action Items:
- Develop provider survey to assess settings (first one done in July 2014, second one being done in January 2015 until March 2015)
- Providers complete it by February 28, 2015
- State and team review and analyze survey responses by March 31, 2015
- Determine compliance for each setting and the remediation and improvements that are needed and issue final report to providers by April 15, 2015
- Summarize results for CMS and amend the waivers beginning May 15, 2015 with developing the report, issuing public comment and notice to tribes, and submitting amendment in July. See Milestone 4.

3. Milestone: Starting in October 2014 and throughout 2019, the state will conduct additional analysis of provider settings with participant, guardian, case manager, and state staff respondents for validity testing of the provider settings and compliance with federal requirements.
Action items:
- State staff analysis of provider surveys by March 31, 2015
- State staff review stakeholder survey information from October 2014 through May 2015
- Develop and disseminate surveys to participants, guardians, case managers, and other stakeholders – Starting in October 2014 and through March 31, 2015 initially, then ongoing through Jan 2019. Review annually in August.
- Collect and analyze responses from stakeholders by March 31, 2015 then ongoing as more surveys are submitted to the Division. Review annually in August.
- Use the Representative Sample Case Review to look at data on participant's satisfaction with service settings, integration, and informed choice – update process starting in July 2015. Review annually in August.
- Use Case Management Quarterly Report data in EMWS to evaluate integration, progress on objectives, satisfaction with services, and employment data - updated process starting in July 2015. Review annually in August.
- Settings that are found to meet any of the following criteria will be subject to the heightened scrutiny process by CMS if requested by the provider and approved by the Department by October 2015 or anytime thereafter before October 2018:
a) The setting is designed to provide people with disabilities multiple types of services and activities on-site, including housing, day services, medical, behavioral and therapeutic services, and/or social and recreational activities.
b) People in the setting have limited, if any, interaction with the broader community.
c) Settings that use/authorize interventions/restrictions that are used in institutional settings or are deemed unacceptable in Medicaid institutional settings (e.g. seclusion).

4. Milestone: In July 2015, the state will submit an amendment to CMS that summarizes the changes needed for Chapter 45, Provider Certification Rules, the new Chapter 46, Rules for the Supports and Comprehensive Waivers, Chapter 44, Rules for Specialized Equipment, Environmental Modifications, and Self Directed Goods and services, service definitions, requirements, policies, compliance for each setting, remediation improvements needed, and changes to processes, provider or facility requirements.
Action items:
- By May 1, 2015, amend the state rules as needed due to the new HCB standards.
- By May 22, 2015, issue public notice and notice to tribes of amendment
- By July 1, 2015, Analyze public comment and make any needed changes to amendment
- By July 22, submit amendment to CMS

5. Milestone: In October 2014, the state conducted Public Forums to review transition plan and gather public input, as required by CMS.
Action items:
- Scheduled forums for October 2014
- Put transition information together
- Presented at forums and receive input on plan

6. Milestone: In November 2014, developed the ABI waiver transition plan to submit to CMS and will evaluate every six months.
Action items:
- Transition plan finalized -October 2014
- Summarize public comment and make changes to draft plans as appropriate –Nov 2014
- Discuss comments with Task Force October 2014
- Providers with areas of non-compliance identified in initial survey results-Nov 2014
- Due dates for remediation identified – March 2015

7. Milestone: By September 2014 and ongoing quarterly through the next five years, the state will develop and deploy a communication strategy to inform and educate participants, guardians, providers, legislators on the new standards and requirements.
Action items:
- Summarize decisions from Transition Task force
- Communicate information to public in multi-media approaches
- Reach all audiences with consistent message and needed changes to state rules and policies
- States must ensure the full Transition Plan is available to the public for public comment, including individuals receiving services, individuals who could be served, and the full stakeholder community.

8. Milestone: By February 2015 and ongoing through 2019, the state will develop a plan for monitoring and enforcing ongoing compliance with the new standards and provider requirements. States must ensure that providers meet the milestones in the ABI transition plan and continue to meet the standards on an ongoing basis.
Action items:
- By July 2015, the state will adjust provider monitoring and on-site visits to ensure compliance with transition plan deadlines to reach compliance with HCB setting standards.
- By July 2015, the state will develop a provider self-assessment to help providers diagnose issues that should be improved or fixed in their organization.
- By October 2015, the state will issue additional information to case managers to help monitor service delivery according to the new standards and report individual progress or issues to the Division.
- By July 2015, the state will use monitoring processes to address areas of non-compliance with standards through certification processes and incident/complaint monitoring processes
- By July 2015, the state will modify and use the Representative Sample Case Review to look at data on participant's satisfaction with service settings, integration, and informed choice
- By July 2015, the state will use the Case Management Quarterly Report data to evaluate integration, progress on objectives, satisfaction with services, and employment data

Year 2 - Milestones for March 17, 2015 to March 16, 2016

9. Milestone: By October 2015, the state will update state rules and laws where required to meet new standards. The state needs to ensure the rules and laws do not conflict with the federal regulations.
Action items:
- The state seeks stakeholder input to adjust rules to meet new standards.
- Rule changes are made according to state procedures.
- State works with legislators to adjust statutes as needed.

10. Milestone: By October 31, 2015 (or anytime thereafter), any provider HCB settings that are fully assessed by the state and found to meet one of the following qualities will be presumed institutional in nature:
a) The setting is designed to provide people with disabilities multiple types of services and activities on-site, including housing, day services, medical, behavioral and therapeutic services, and/or social and recreational activities.
b) People in the setting have limited, if any, interaction with the broader community.
c) Settings that use/authorize interventions/restrictions that are used in institutional settings or are deemed unacceptable in Medicaid institutional settings (e.g. seclusion).

If notified of this status, the provider may ask the state to request approval from CMS to be considered HCB because of the other HCB qualities and individual experiences that meet the federal standards. Through the ongoing analysis of settings, if any setting is found to be Non-HCB based on the new rules, but the state determines that evidence proves it should be considered HCB, the state must provide the evidence to CMS and the setting is subject to approval through the heightened scrutiny process. Requests to CMS, if determined appropriate by the state, will be submitted during November 2015 and go through the heightened scrutiny process.
Action items:
- By March 31, 2015 the preliminary HCB Setting analysis will be completed to determine which settings are out of compliance and are "flagged" for corrective action
- By April 15, 2015 the state will issue providers a report of findings and require the provider to develop a detailed corrective action plan with a transition plan by October 2015.
- By October 31, 2015 (or any time after this deadline if compliance issues are found), if a setting meets one of the listed criteria in this milestone, the setting may be subjected to the heightened scrutiny process by CMS.
- For settings found to be institutional in nature, the provider may request the state submit an exception to CMS and will provide evidence of how each setting:

a) Supports full access to the greater community to the same degree as individuals not receiving Medicaid HCBS.
b) Is selected by the individual from options including non-disability specific settings.
c) Ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint.
d) Optimizes individual independence in making life choices including daily activities, physical environment, and with whom to interact.

e) Facilitates individual choice regarding services and supports, and who provides them.

 The state will submit a detailed request with evidence by October 31, 2015 for settings that are deemed not HCB, which the state elects to be subject to the heightened scrutiny process by CMS. If any apply, the request will be submitted by November 30, 2015 or at any time a different decision is made by the state for a setting.

11. Milestone: By April 15, 2015, each provider with an HCB setting that has areas of noncompliance with the new standards found by state staff will be issued a Corrective Action Plan for any of the following standards where their residential setting is not in compliance.

- A lease or written residency agreement with each participant
- Each individual has privacy in their sleeping or living unit
- Units have lockable entrance doors, with the individual and appropriate staff having keys to doors as needed
- Individuals sharing units have a choice of roommates
- Individuals have freedom to furnish and decorate within the lease/agreement
- Individuals have freedom and support to control their schedules and activities and have access to food any time
- Individuals may have visitors at any time
- The setting is physically accessible to the individual

Providers will be able to uniquely adjust or restructure their business to meet the standards.

Action items:

 By March 31, 2015, a full setting analysis completed to determine which setting are out of compliance and are “flagged” for corrective action

 By April 15, 2015, Providers will be issued a report of findings and areas that need corrections

 By October 1, 2015, each provider’s transition plan must be submitted to the Division for approval and must include milestones and timeframes that outline how and when they will correct each requirement by October 1, 2018.

 Providers have until October 1, 2018 to come into compliance in all areas. Ongoing from October 2015 to October 2018, the state will meet with each provider that has a setting found to be in jeopardy of noncompliance and requiring disenrollment in 2019 to discuss all options, areas to improve, and meet with participants, guardians and stakeholders as necessary.

12. Milestone: By October 2015, any provider found out of compliance with an HCB standard in any setting must develop and implement a transition plan to make changes in order to meet the standards. The provider must ensure the policies and practices of their organization are changed where appropriate and that board members, staff, participants and guardians are aware of the systemic changes. Providers will be able to uniquely adjust or restructure their business to meet the standards within the four years left in the transition plan, but must report annual progress on milestones.

Action Items:

 By April 15, 2015, providers will be issued a report of where they are not in compliance with specific settings.

 By October 1, 2015, providers must develop and submit a detailed action plan with milestones and timelines each year that outline the changes or actions that will be taken in order to come into full compliance with all HCB standards October 1, 2018.

The transition plan will require providers develop or update operating policies and procedures to address how they will demonstrate that each setting:

a) Is integrated in and supports full access to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community to the same degree as individuals not receiving Medicaid HCBS.
b) Is selected by the individual from options including non-disability specific settings.
c) Ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint.
d) Optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices including daily activities, physical environment, and with whom to interact.
e) Facilitates individual choice regarding services and who provides them.

 By October 1, 2015, the state will develop provider self-assessment to assist the provider in adjusting business practices to meet the standards.

 From July 2015 and ongoing, the state will work with providers to make adjustments to the action plan, if needed.

 By October 31, 2015 the state must approve each provider transition plan.

13. Milestone: By March 1, 2016, participants who need a modification to a right specified in the new standards must have the modification or restriction identified and documented in a signed plan of care approved by the state according the requirements listed in § 441.301(c)(4)(vi)(A) through (D). Participants must have their rights protected. Any modification to their rights must be fully documented and explored by the team according to the new HCB standards.

Action items:

 By July 1, 2015, the state will revise the electronic plan of care to include the new standards for restricting a person’s right.

 By January 31, 2016, the Case manager will work the participant’s plan of care team to inform the participant and guardian of their rights in the new regulations.

 By February 1, 2016, the team must address the following items for any modification or restriction to a person’s right in the plan of care:

a) Identify a specific and individualized assessed need.
b) Document the positive interventions and supports used prior to any modifications to the person-centered service plan.
c) Document less intrusive methods of meeting the need that have been tried but did not work.
d) Include a clear description of the condition that is directly proportionate to the specific assessed need.
e) Include regular collection and review of data to measure the ongoing effectiveness of the modification.
f) Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.
g) Include the informed consent of the individual.
h) Include an assurance that interventions and supports will cause no harm to the individual.

 By February 1, 2016, the modifications to the plans of care will be submitted to the Division for review and approval by March 1, 2016.

14. Milestones: By March 1, 2016, the participant’s team documents in the plan of care, which is signed by the participant or guardian, how the HCB setting(s) chosen in the plan:

a) Is integrated in and supports full access to the greater community to the same degree as individuals not receiving Medicaid HCBS.
b) Is selected by the individual from options including non-disability specific settings.
c) Ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint.
d) Optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices including daily activities, physical environment, and with whom to interact.
e) Facilitates individual choice regarding services and supports, and who provides them.

The plan of care is developed using person-centered practices to ensure the providers know how to support the person in an individualized fashion. The plan approval process ensures the participant and guardian signs and approves the how services will be delivered.

Action items:

- By January 31, 2016, each Participant has choice and information provided according to the new standards.
- By July 1, 2015, the state will revise the electronic plan of care to include the new standards and offer guidance on how to complete the sections using person-centered practices.
- By February 1, 2016, the case manager shall submit the revised plan of care to the Division for review and approval by March 1, 2016.

15. Milestone: By December 31, 2015, the approved ABI waiver Five Year Transition plan will be implemented and evaluated.
Action items:
- The five year transition plan for this waiver will be further implemented and evaluated for its progress. Feedback will be acquired through surveys and stakeholder meetings.
- Any substantial changes to a Transition Plan will incorporate the public notice and input process into that submission.

16. Milestone: By March 1, 2016, the state will develop and monitor a plan to address provider capacity and setting capacity if issues with capacity arise. The state must ensure that the participants served on the waivers and the number of providers and settings available are equitable.
Action items:
- By March 1, 2016, the state will provide training and support to providers to assist with provider stability and capacity.
- By March 1, 2016, areas of the state with provider shortages will be reviewed and addressed.
- By March 1, 2018, the state will address shortage issues that may result due to the changes required in the provider setting standards.

17. Milestone: By March 1, 2016, the state will implement changes to provider monitoring practices to oversee the provider compliance to their own transition plans and milestones. CMS requires the state to ensure the provider is meeting state standards and must address areas of noncompliance through technical assistance, corrective action plans or other sanctioning actions.
Action items:
- By March 1, 2016, Provider surveying and monitoring practices by the state will be adjusted to check for compliance with the standards and the provider's action plan for transitioning.
- By March 1, 2016, the state's process for issuing corrective action will be used in areas of non-compliance found with the provider's own transition plan.

18. Milestone: Throughout 2015-16, the state will deploy a communication strategy to inform participants, guardians, providers, legislators.
Action items:
- The state will continue use multiple communication channels to get the information out about the transition plans, new standards, and any areas of concern that need attention.
- Legislators will be contacted with information on the status of the transition plan and setting progress.

Year 3 - Milestones for March 17, 2016 to March 16, 2017

19. Milestone: By March 1, 2017, providers will continue to implement transition plan and report progress to the state during recertification processes. Any business changes and policy changes should be evaluate regularly and adjusted as appropriate.
Action Items:
- By March 1, 2017, providers will meet milestones in their transition plans and inform staff, participants and guardians regarding the changes in their programs.
- By March 1, 2017, policies and practices will be evaluated and adjusted depending on feedback and issues that arise.
- By March 1, 2017, adjustments to provider action plans for the transition must be review by the state to ensure the changes still meet the standards.

20. Milestone: By October 31, 2016 and after the state has completed another year of site visits, monitoring and provider recertifications, if the state determines any provider settings are non-HCB, the provider will be notified that it must come into full compliance with the HCB standards by October 1, 2018. If requested by the provider, the state will determine by October 31, 2016 if the setting should be submitted to CMS for heightened scrutiny. If the state determines any provider settings are non-HCB, the provider will be notified that it must change or repurpose the setting that does not comply with the HCB standards.
Action Items:
- After the state has completed site visits, monitoring and provider recertifications during 2015 and 2016, if the state determines any provider settings are non-HCB, the provider will be notified that it must come into full compliance with the HCB standards by October 1, 2018.
- If requested by the provider, the state will determine by October 31, 2016 if the setting should be submitted to CMS for heightened scrutiny in November 2016.

Year 4 - Milestones for March 17, 2017 to March 16, 2018

21. Milestone: By December 1, 2017, the state will require a Corrective Action Plan (CAP) to be submitted within 30 days from providers if they have a setting found not in compliance. In the CAP, the provider must make final action plans regarding the changes to settings they will make to meet HCB standards or list how they will notify participants, guardians and case managers to help participants transition to new service settings by March 1, 2019.
Action Item:
- By January 1, 2018, if a providers has a service setting that does not meet the new standards, the provider will be required by the state to submit a corrective action plan within 30 days that details how they will move or repurpose a setting, or transition participants out of the setting, so that participants are not served in the setting by March 1, 2019.

22. Milestone: By March 2018, providers continue to implement transition plan and report progress to the state during recertification processes.
Action items:
- Providers meet milestones in their transition plans and inform staff, participants and guardians regarding the changes in their programs.
- Policies and practices are evaluated and adjusted depending on feedback and issues that arise.
- Adjustments to provider action plans for the transition must be review by the state to ensure the changes still meet the standards.
- Business changes and policy changes must be evaluate regularly and adjusted as appropriate.

Year 5 - Milestones for March 17, 2018 to March 16, 2019

23. Milestone: By October 1, 2018, Providers make final adjustments to meet and maintain compliance with all HCB setting standards.
Action Items:
- All provider settings must be in compliance by October 1 of year 5.
- State staff will evaluate all progress made by providers on their transition plans and address areas of non-compliance or unmet milestones and issue corrective action plans and or sanctions at the end of year five.

24. Milestone: By November 1, 2018, the waiver transition plan will receive a final evaluation by Division administrators.

24. Milestone: By November 1, 2018, the waiver transition plan will receive a final evaluation by Division administrators.
Action items:
- The ABI waiver transition plan is further implemented and evaluated for its progress.
- Feedback will be acquired through surveys and stakeholder meetings.
- Any substantial changes to a Transition Plan must incorporate the public notice and input process into that submission

25. Milestone: By November 1, 2018, the state will notify providers of any setting that will be disenrolled from waiver funding due to noncompliance.

26. Milestone: By November 1, 2018, the state will issue notification to the participants and their case managers who receive services in noncompliant settings that the funding for services in those settings is discontinuing effective March 17, 2019 so the participants can be offered a choice in other providers and begin the transition process.

27. Milestone: By March 1, 2019, waiver participants must have completed the transition to new settings, if needed. By November 1, 2018, any participants (and their case managers) that are served in a setting that does not meet HCB standards will receive notice to choose another setting and possibly a new provider. If participant chooses to remain in a non-compliant setting waiver funding cannot be used.
Action items:
- Ongoing from October 2015 to October 2018, the state will meet with each provider that has a setting found to be in jeopardy of noncompliance and requiring disenrollment in 2019 to discuss all options, areas to improve, and meet with participants, guardians and stakeholders as necessary.
- Participants must begin choosing providers or new settings, having transition plans or transitioning off of the waiver if wanting to stay in a non-compliant setting. All services to participants must be in compliant settings by March 1, 2019 to ensure the state is in full compliance with CMS rules by March 16, 2019.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Appendix A: Waiver Administration and Operation

1. State Line of Authority for Waiver Operation. Specify the state line of authority for the operation of the waiver (*select one*):

- (•) **The waiver is operated by the State Medicaid agency.**

  Specify the Medicaid agency division/unit that has line authority for the operation of the waiver program *(select one)*:

  - ( ) **The Medical Assistance Unit.**

    Specify the unit name:

    (Do not complete item A-2)
  - (•) **Another division/unit within the State Medicaid agency that is separate from the Medical Assistance Unit.**

    Specify the division/unit name. This includes administrations/divisions under the umbrella agency that has been identified as the Single State Medicaid Agency.

    Behavioral Health Division

    (Complete item A-2-a).
- ( ) **The waiver is operated by a separate agency of the State that is not a division/unit of the Medicaid agency.**

  Specify the division/unit name:

  In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this policy is available through the Medicaid agency to CMS upon request. *(Complete item A-2-b).*

Appendix A: Waiver Administration and Operation

2. Oversight of Performance.

a. Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency. When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities:

The functions and responsibilities of the Behavioral Health Division for the administration and operation of the Behavioral Health Division Waivers, which includes the Support (1060), Comprehensive (1061), Child Developmental Disabilities (0253), Adult Developmental Disabilities (0226), Acquired Brain Injury (0370), and Children's Mental Health (0451) Home and Community-Based Services Waivers:

A. Develop and implement policies, procedures and general guidance for the operation of the BHD Waivers after review and approval by State Medicaid Agent;
B. Develop and implement policies, procedures and general guidance for quality assurance as related to the BHD Waivers after review and approval by State Medicaid Agent;
C. Develop administrative rules, contracts, written policies and procedures, and subsequent revisions related solely to BHD Waivers and submit to State Medicaid Agent for review and approval;
D. Verify qualifications, certify providers, and provide quarterly certification reports to State Medicaid Agent;
E. Submit changes to the provider certification process to State Medicaid Agent for approval before implementation;
F. Monitor providers to ensure compliance with the BHD policies and procedures, operational and quality assurance standards, service definitions and billing procedures, rules, regulations and guidelines and provide quarterly monitoring reports to State Medicaid Agent;
G. Monitor utilization, expenditures, participant counts, projected costs, and waiting list information in relation to approved waiver and provide quarterly reports to State Medicaid Agent. The fiscal staff will assist with the determination of actual and projected costs;
H. Track waiver performance measure data (quality assurances) and trends and provide quarterly reports to State Medicaid Agent;
I. Set and implement provider rates after approval by State Medicaid Agent.

(b) The document utilized to outline the roles and responsibilities related to waiver operation:

The Department of Health has a Letter of Agreement between the Division of Healthcare Financing and the Behavioral Health Division, which outlines the roles and responsibilities related to waiver administration and operations and documents the administrative authority of the State Medicaid Agent for the operation of the BHD Waivers.

(c) Methods that are employed by the State Medicaid Director in the oversight of these activities:

The Wyoming Department of Health is the State Medicaid Agency and the ABI Waiver is operated by the Behavioral Health Division within the Department of Health, under the direction of the State Medicaid Agent. The State Medicaid Agent reports to the Director of the State Medicaid Agency through the Deputy Director of Administration.

The Administrator of the Behavioral Health Division reports to the Director of the State Medicaid Agency through the Deputy Director of Administration. There is a Letter of Agreement between the Division of Healthcare Financing and BHD outlining the responsibilities of each entity. A Medicaid Programs Coordinator position within Medicaid acts as a liasion to the waiver managers and exercises maximize oversight of and involvement in the day to day operations of the HCBS waivers. This position reports directly to the State Medicaid Agent. Under the direction of the State Medicaid Agent, the Programs Coordinator has oversight over the administrative and operational functions of the waiver performed by BHD and works closely with the Program Integrity Manager within Medicaid to identify areas that need increased involvement and oversight by the State Medicaid Agent. The State Medicaid Agent, Programs Coordinator, Program Integrity Manager, Senior Eligibility Manager, and Operations Manager, who combined provide oversight over all areas of the Medicaid waivers, report directly to the State Medicaid Agent within the Division of Healthcare Financing.

The State Medicaid Agent or her designee:

A. Reviews and approves policies, procedures and guidance related to the operation of the BHD Waivers;
B. Reviews and approves policies, procedures and guidance for quality assurance related to the BHD Waivers;
C. Reviews and approves administrative rules, contracts, written policies and procedures, and subsequent revisions drafted by BHD;
D. Reviews quarterly certification reports provided by BHD;
E. Reviews and approve changes to BHD's certification process;
F. Reviews quarterly provider monitoring reports provided by BHD;
G. Reviews quarterly reports on utilization, expenditures, participant counts, projected costs, and waiting list information provided by BHD;
H. Reviews quarterly reports on waiver performance measure data and trends provided by BHD;
I. Reviews and approve changes to provider rates before implementation by BHD.

The Programs Coordinator has regular contact with the Waiver managers at BHD. A monthly meeting is held by the Programs Coordinator for representatives from all Home and Community Based Services waivers. The BHD Communications, Policy, Research and Training managers represents BHD at these meetings. The goal of these meetings is to keep the Programs Coordinator abreast of the day to day management activities of the waivers, to create as much consistency across the waivers as possible, and to provide adequate oversight of the waiver programs to ensure compliance with federal and state regulations and requirements. The direct supervisors of the Waiver Managers often attend these meetings and are kept current on requirements and concerns through additional status meetings and e-mails. After reviewing quarterly performance measure reports for the waiver, these monthly Waiver meetings will provide feedback to the Waiver representatives from the State Medicaid Agent or her designee. Additionally, the Programs Coordinator holds meetings quarterly with the BHD Waiver staff to discuss information from management reports on topics such as utilization, expenditures, participant counts, waiting lists, and performance measure data trends.

The Medicaid Agent is represented by one or more designated staff at BHD meetings concerning HCBS waivers such as ECC and Mortality Review. Agenda items are documented, discussed, and tracked until resolution. BHD waiver staff attend monthly CURT (Core Utilization Review Team) meetings, and monthly MMIS status meetings.

b. Medicaid Agency Oversight of Operating Agency Performance. When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. Specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:

As indicated in section 1 of this appendix, the waiver is not operated by a separate agency of the State. Thus this section does not need to be completed.

Appendix A: Waiver Administration and Operation

3. Use of Contracted Entities. Specify whether contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable) (*select one*):

Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).

Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:*

Medicaid has a contract for the operation and management of the MMIS system to review and pay all claims submitted by providers for the BHD waivers. This Contractor assists the State with Prior authorization, provider enrollment, and the execution of provider agreements. For prior authorization, the Contractor generates the prior authorization number after BHD uploads the approved service plan into the client database which interfaces with the MMIS system. For provider enrollment, the Contractor processes the Medicaid provider enrollment application after the Division certifies the provider. For provider agreements, the Contractor executes and stores the provider agreements according to contractor requirements.

Medicaid has a Utilization Review contract which includes case review for BHD's Mortality Review Committee. Cases reviewed by the committee include ABI waiver participants.

BHD through the SMA has a contractor to conduct Inventory for Client and Agency Planning (ICAPs) for ABI Waiver applicants and participants as part of the eligibility and level of care process for the waiver.

BHD through the SMA has a contractor to provide Financial Management Services for participants or their representatives self-directing services on the ABI Waiver. The contractor completes all responsibilities related to self-direction as described in Appendix E of this application, bills MMIS for services provided by participants' workers, tracks utilization of services by participant, provides utilization information on a monthly basis to participant, case manager, support broker and DD Division, processes time sheets and pays workers.

BHD through the SMA has a contractor to manage the Electronic Medicaid Waiver System. This system maintains applicant and participant eligibility, annual plans of care, modifications, and other documents. This system interfaces with the provider certification database, IMPROV, and the MMIS system.

○ **No. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).**

Appendix A: Waiver Administration and Operation

4. Role of Local/Regional Non-State Entities. Indicate whether local or regional non-state entities perform waiver operational and administrative functions and, if so, specify the type of entity (*Select One*):

◉ **Not applicable**

○ **Applicable -** Local/regional non-state agencies perform waiver operational and administrative functions.

Check each that applies:

☐ **Local/Regional non-state public agencies** perform waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the State and these agencies that sets forth responsibilities and performance requirements for these agencies that is available through the Medicaid agency.

Specify the nature of these agencies and complete items A-5 and A-6:

☐ **Local/Regional non-governmental non-state entities** conduct waiver operational and administrative functions at the local or regional level. There is a contract between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state entity that sets forth the responsibilities and performance requirements of the local/regional entity. The **contract(s)** under which private entities conduct waiver operational functions are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Specify the nature of these entities and complete items A-5 and A-6:

Appendix A: Waiver Administration and Operation

5. Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities. Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:

The Division of Healthcare Financing, within the State Medicaid Agency (Department of Health), has a MMIS Contract Manager who assesses the on-going performance of the MMIS Contractor, which is Xerox. Additionally, the Program Integrity Manager and Programs Coordinator (within the Division of Healthcare Financing) and the BHD Provider Support Manager or designee (within BHD) review information provided under this contract related to prior authorization, provider enrollment, and provider agreements.

The Division of Healthcare Financing, within the State Medicaid Agency (Department of Health), has a Utilization Contract Manager who assesses the ongoing performance of the Utilization Review Contractor, including work related to mortality reviews for the Comprehensive Waiver. Additionally, the Provider Support Manager in BHD (who is the Chair of the DD Mortaility Review Committee) reviews information provided under this contract related to mortality review.

The BHD through the SMA uses the Participant Support Manager to monitor the timeliness of the ICAPs conducted to ensure compliance with the contract.

The BHD through the SMA uses the Provider Support Manager to oversee the monitoring process for the Financial Management Service provider, which includes a review of records to assure adherence to IRS and federal, state and local rules and regulations, timely and accurate processing of time sheets, timely and accurate maintaining of current participant budget information, and assessment of participant/representative and worker satisfaction with FMS services. Processes are explained in Appendix E of this application.

The BHD through the SMA uses the Participant Support Manager to oversee the contractor to manage the Electronic Medicaid Waiver System (EMWS), including oversight and direction of enhancements, maintenance, role access, testing, accuracy of data, and user training needs. The manager also oversee the system interfaces with the provider certification database, IMPROV, and the MMIS system to ensure tasks and projects are being addressed.

Appendix A: Waiver Administration and Operation

6. **Assessment Methods and Frequency.** Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:

The MMIS Contract Manager in the Division of Healthcare Financing continually assesses the performance and compliance of the contractor based on requirements in the RFP and contract, and the Business Rules provided to the contractor. Monthly contract management meetings are held by the Contract Manager with the contractor to review the status of projects and to address any identified problems. Regular status meetings are held by the contractor to update the Contract Manager and to review project lists and monitor timelines for completion. Meeting Minutes are recorded and distributed to each person who attends the meeting. The MMIS Contract Manager communicates identified contract issues to the Waiver representatives, Program Integrity Manager, and Medicaid Programs Coordinator as necessary.

The Contract Manager for the Utilization Review contract continually assesses the performance and compliance of the contractor based on requirements in the RFP and contract. Weekly contract management meetings are held by the Contract Manager with the contractor to review the status of projects and to address any identified problems. The Contract Manager attends the quarterly Mortality Review Committee meetings held by BHD and monitors the case review information provided by the Contractor for the meetings. Monitoring criteria includes but is not limited to making sure the Contractor requested and obtained records based on the appropriate claim period, did an objective and thorough case review, and submitted timely written reports of the findings to the BHD Provider Support Manager for use at the meetings.

The BHD Participant Support Manager monitors the timeliness of the ICAPs conducted monthly to ensure compliance with the contract. The contractor records the time it took to complete each ICAP on a spreadsheet which is submitted to the BHD monthly for review. BHD also monitors any concerns with the ICAPs conducted and meets with the contractor as needed to follow up on concerns. The Medicaid Agent or her designee in the Division of Healthcare Financing will review the quarterly Management Report provided by BHD which details oversight activities and findings.

The state has developed a tiered approach to monitoring the performance of the Vendor Fiscal Employer Agent Financial Management Service, including oversight by the case manager, BHD, and the Medicaid Program Integrity Unit.

1. The case manager reviews the performance of the Vendor Fiscal Employer Agent Financial Management service during the required monthly home visit with the participant. The case manager is required to document the specific concerns, complete and document follow-up actions to address the concerns, and assure the concerns are resolved. Follow-up actions include, as appropriate:
• Direct contact with the Fiscal Employer Agent Financial Management Service informing them of concerns and working with them to resolve the issues.
• Meeting with appropriate parties involved, including the Support Broker, employee of participant who is involved in situation, and Vendor Fiscal Employer Agent Financial Management Service representative, to work through the concerns.
• Reporting issues to BHD if significant concerns are identified that impact health and safety, indicate potentially fraudulent activity, and/or if concerns are not addressed by Vendor Fiscal Employer Agent Financial Management after the case manager has worked directly with them. A summary of issues reported and action taken by BHD are be forwarded to the State Medicaid Agent or her designee.

2. BHD monitors the Vendor Fiscal Employer Agent Financial Management Service through the following processes:
• Monitoring the Vendor Fiscal Employer Agent Financial Management monthly budget utilization reports for all participants self-directing services to assure reports are accurately reflecting service utilization, reviewing flagged participants who are over utilizing or under utilizing their budgets, and business rules are adhered to, including rules on service limitations.
• Completing a bi-annual review of Vendor Fiscal Employer Agent Financial Management Services for a representative sample of individuals utilizing this service. The representative sample will have a confidence interval of 95% +/- 5% error rate. The review will include: (1) a review of individuals' files to verify the Vendor Fiscal Employer Agent Financial Management Service has all employee information on an individual and verification of withholdings as detailed in Appendix E (2)customer satisfaction interviews with both the common law employer (participant or their legal representative) and employees to assess the satisfaction of Fiscal Employer Agent Financial Management Service, including timely processing of timesheets, timely resolution to customer service calls and complaints, and assistance in completing enrollment packets and (3)a review of the Vendor Fiscal Employer Agent's contract

3. Based on the representative sample pulled by BHD, the Medicaid Program Integrity Unit reviews claims paid to providers through the following processes:
* Reviewing claims paid to the Vendor Fiscal Employer Agent Financial Management Service and supporting documentation to verify that the documentation supports the billing and payment for services.
* Recovering funds paid to the Vendor Fiscal Employer Agent for claims for which services are not sufficiently documented.
BHD completes an annual review of the Vendor Fiscal Employer Agent business practices to verify all required IRS regulations, as well as state unemployment and worker's compensation regulations. BHD requests a copy of independent audits conducted by the vendor. If concerns are found through any of these processes the Vendor Fiscal Employer Agent Financial Management Service will be required to address the concerns within a specified time period, and, when applicable, to pay corresponding penalties and fees. The vendor's contract includes clauses for termination of contract if serious concerns are identified. A summary of review findings are forwarded to the State Medicaid Agent or her designee.

The contractor for the EMWS is assessed by BHD Participant Support Manager and DD Section Administrator through weekly update meetings on the enhancement and maintenance task lists. The manager tests the system for accuracy of data, needed upgrades, and prioritization of upgrade tasks. There are also frequent discussions and follow up with the Medicaid Programs Coordinator and other waiver programs who use the system to oversee the performance of the contractor. Notes on these meeting are recorded. The BHD Administrator holds steering committee meetings as needed on the EMWS project with the contractor and other state agency staff to ensure the deliverables of the contract are being fulfilled before payment is issued. Follow up is completed by the BHD manager or Administrator with the lead system expert at the contractor when issues come up that need immediate or extra attention.

Appendix A: Waiver Administration and Operation

7. **Distribution of Waiver Operational and Administrative Functions.** In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):
In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. *Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.*

Function	Medicaid Agency	Contracted Entity
Participant waiver enrollment	☑	☐
Waiver enrollment managed against approved limits	☑	☐
Waiver expenditures managed against approved levels	☑	☐
Level of care evaluation	☑	☐
Review of Participant service plans	☑	☐
Prior authorization of waiver services	☑	☑
Utilization management	☑	☑

Function	Medicaid Agency	Contracted Entity
Qualified provider enrollment	☑	☑
Execution of Medicaid provider agreements	☑	☑
Establishment of a statewide rate methodology	☑	☐
Rules, policies, procedures and information development governing the waiver program	☑	☐
Quality assurance and quality improvement activities	☑	☐

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Administrative Authority

The Medicaid Agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities.

i. Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Performance measures for administrative authority should not duplicate measures found in other appendices of the waiver application. *As necessary and applicable, performance measures should focus on:*

- Uniformity of development/execution of provider agreements throughout all geographic areas covered by the waiver
- Equitable distribution of waiver openings in all geographic areas covered by the waiver
- Compliance with HCB settings requirements and other new regulatory components (for waiver actions submitted on or after March 17, 2014)

Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
1 Percentage of Inventory for Client and Agency Planning (ICAP) assessments for Waiver participants completed within an average of 30 calendar days from the date the ICAP was requested (the total number of ICAP assessments completed within an average of 30 calendar days of request divided by the total number of ICAPs requested)

Data Source (Select one):
Other
If 'Other' is selected, specify:
ICAP spreadsheet report with dates of requests and completions

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
2 Percentage of waiver prior authorization error reports which are reviewed by Medicaid to assess Contractor performance. (the total number of waiver prior authorization reports reviewed by Medicaid divided by the number of waiver prior authorization error reports created)

Data Source (Select one):
Other
If 'Other' is selected, specify:
Reports to State Medicaid Agency on delegated Administrative functions

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
3 Percentage of rules, contracts, rates, and policies/procedures related submitted by BHD that have been approved by the State Medicaid Agent or designee prior to implementation.(the total number of rules, contracts, rates, policies/procedures approved by SMA prior to implementation divided by the total number of rules, contracts, rates, and policies/procedures implemented by BHD)

Data Source (Select one):
Other
If 'Other' is selected, specify:
database

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis*(check each that applies):*
	☐ Continuously and Ongoing
	☐ Other Specify:

Performance Measure:
4 Percentage of quarterly reports completed by the BHD Division for which a feedback meeting is held by the State Medicaid Agent or her designee to provide recommendations and direction. (the total number of feedback meetings held by the State Medicaid Agent or designee divided by the number of quarterly reports submitted by the BHD for review)

Data Source (Select one):
Other
If 'Other' is selected, specify:
minutes from meetings

Responsible Party for data collection/generation*(check each that applies):*	Frequency of data collection/generation*(check each that applies):*	Sampling Approach*(check each that applies):*
☑ State Medicaid Agency	☐ Weekly	☑ 100% Review
☐ Operating Agency	☐ Monthly	☐ Less than 100% Review
☐ Sub-State Entity	☑ Quarterly	☐ Representative Sample Confidence Interval =
☐ Other Specify:	☐ Annually	☐ Stratified Describe Group:
	☐ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis*(check each that applies):*
☑ State Medicaid Agency	☐ Weekly
☐ Operating Agency	☐ Monthly
☐ Sub-State Entity	☐ Quarterly
☐ Other Specify:	☑ Annually
	☐ Continuously and Ongoing
	☐ Other Specify:

Performance Measure:	
Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*

5 Percentage of Contractor reports provided to the Mortality Review Committee that were complete. (total number of Mortality Review Committee reports that were complete divided by the number of Mortality Review Committee reports that were submitted by Contractor)

Data Source (Select one):
Other
If 'Other' is selected, specify:
database

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
6 Percentage of monthly call center reports and other usage reports reviewed by BHD Division to assess Contractor performance. (total number of monthly reports reviewed by BHD Division divided by the number of monthly reports submitted by Contractor to the BHD Division)

Data Source (Select one):
Other
If 'Other' is selected, specify:
database from contractor

Responsible Party for data collection/generation *(check each that applies):*	Frequency of data collection/generation *(check each that applies):*	Sampling Approach *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

Methods for remediation with contractors include: verbal and/or written notification to the contractor about any concerns the State has with performance as soon as they are identified, education and guidance provided to the Contractor stating the State's expectations for performance under the contract, and modifying the language in the contract to more clearly articulate the expectations of the State. If contract performance does not improve, the contract can be terminated.

Methods for remediation with the Division include feedback given by the Medicaid Programs Coordinator to the BHD Unit manager specific to the topic of feedback, and if necessary, feedback given by the State Medicaid Agent to the BHD Administrator about expectations related to the operation of the waiver. If that communication is not successful in resolving the concern, concerns can be discussed at monthly Department of Health Senior Management meetings, directed by the head of the State Medicaid Agency.

ii. Remediation Data Aggregation

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Administrative Authority that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Administrative Authority, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix B: Participant Access and Eligibility

B-1: Specification of the Waiver Target Group(s)

a. Target Group(s). Under the waiver of Section 1902(a)(10)(B) of the Act, the State limits waiver services to one or more groups or subgroups of individuals. Please see the instruction manual for specifics regarding age limits. *In accordance with 42 CFR §441.301(b)(6), select one or more waiver target groups, check each of the subgroups in the selected target group(s) that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup:*

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
☐ **Aged or Disabled, or Both - General**					
	☐	**Aged**			☐
	☐	**Disabled (Physical)**			
	☐	**Disabled (Other)**			
☑ **Aged or Disabled, or Both - Specific Recognized Subgroups**					
	☑	**Brain Injury**	21	64	☐
	☐	**HIV/AIDS**			☐
	☐	**Medically Fragile**			☐
	☐	**Technology Dependent**			☐
☐ **Intellectual Disability or Developmental Disability, or Both**					
	☐	**Autism**			☐
	☐	**Developmental Disability**			☐
	☐	**Intellectual Disability**			☐
☐ **Mental Illness**					
	☐	**Mental Illness**			
	☐	**Serious Emotional Disturbance**			

b. Additional Criteria. The State further specifies its target group(s) as follows:

Additional targeting criteria for eligibility on the ABI Waiver includes:

Medical Eligibility - Determined by a licensed physician and registered nurse who reviews the medical documentation submitted by the applicant and verifies that this documentation meets the definition of acquired brain injury as listed below:

Acquired Brain Injury - any combination of focal and diffuse central nervous system dysfunction. Both immediate and/or delayed, at the brain stem level and above. These dysfunctions are acquired through the interaction of any external forces and the body, oxygen deprivation, infection, toxicity, surgery and vascular disorders not associated with aging. It is an injury to the brain that has occurred since birth. It may have been caused by an external physical force or by a metabolic disorder(s). The term acquired brain injury includes traumatic brain injuries such as open or closed head injuries and non traumatic brain injuries such as those caused by strokes, tumors, infectious diseases (e.g. encephalitis or meningitis), hypoxic injuries (e.g. asphyxiation, near drowning, anesthetic incidents, or severe blood loss), metabolic disorders (e.g., insulin shock or liver or kidney disease), and toxic products taken into the body through inhalation or ingestion. The term does not include brain injuries that are congenital or brain injuries induced by birth trauma. These dysfunctions are not developmental or degenerative.

Clinical Eligibility
A neuropsychological examination will be administered by a licensed psychologist who has at least one year of post doctoral work in acquired brain injury. The neuropsychological examination will confirm that the individual meets the ABI definition and meets any of the following functional criteria:

Mayo Portland Adaptability Inventory (MPAI) score of 42 or more
California Verbal Learning Test II Trials 1-5 T score of 40 or less
Supervision Rating Scale score of 4 or more
Inventory for Client and Agency Planning(ICAP) service score of 70 or less (ICAP administered by a contracted agency)

c. Transition of Individuals Affected by Maximum Age Limitation. When there is a maximum age limit that applies to individuals who may be served in the waiver, describe the transition planning procedures that are undertaken on behalf of participants affected by the age limit *(select one):*

- ○ **Not applicable. There is no maximum age limit**
- ◉ **The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit.**

Specify:

Individuals who are already receiving services on the ABI waiver and turns 65 years old may remain receiving waiver services. No one 65 or older may apply for waiver services.

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (1 of 2)

a. Individual Cost Limit. The following individual cost limit applies when determining whether to deny home and community-based services or entrance to the waiver to an otherwise eligible individual *(select one)*. Please note that a State may have only ONE individual cost limit for the purposes of determining eligibility for the waiver:

- ○ **No Cost Limit.** The State does not apply an individual cost limit. *Do not complete Item B-2-b or item B-2-c.*
- ○ **Cost Limit in Excess of Institutional Costs.** The State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the State. *Complete Items B-2-b and B-2-c.*

  The limit specified by the State is *(select one)*

  - ○ **A level higher than 100% of the institutional average.**

    Specify the percentage:

  - ○ **Other**

    Specify:

- ◉ **Institutional Cost Limit.** Pursuant to 42 CFR 441.301(a)(3), the State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. *Complete Items B-2-b and B-2-c.*
- ○ **Cost Limit Lower Than Institutional Costs.** The State refuses entrance to the waiver to any otherwise qualified individual when the State reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the State that is less than the cost of a level of care specified for the waiver.

  Specify the basis of the limit, including evidence that the limit is sufficient to assure the health and welfare of waiver participants. Complete Items B-2-b and B-2-c.

The cost limit specified by the State is *(select one)*:

- **The following dollar amount:**

  Specify dollar amount:

  The dollar amount *(select one)*

  - **Is adjusted each year that the waiver is in effect by applying the following formula:**

    Specify the formula:

  - **May be adjusted during the period the waiver is in effect. The State will submit a waiver amendment to CMS to adjust the dollar amount.**

- **The following percentage that is less than 100% of the institutional average:**

  Specify percent:

- **Other:**

  Specify:

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (2 of 2)

b. Method of Implementation of the Individual Cost Limit. When an individual cost limit is specified in Item B-2-a, specify the procedures that are followed to determine in advance of waiver entrance that the individual's health and welfare can be assured within the cost limit:

Once there is a funding opportunity, the Division generates the individualized budget amount and notifies the participant and/or guardian of the funding opportunity and of their budgeted amount. Using a person-centered approach, the participant, the case manager and the team work together to develop a plan of care that will allocate that individualized budget amount for needed waiver services. The plan of care also identifies non-waiver services needed by the participant. If the participant and/or guardian with support from the plan of care team identifies that the plan of care developed within the budgeted amount will not meet the participant's health and welfare needs the participant can request additional funding through the Division"s Extraordinary Care Committee, described below.

The additional funding being requested cannot exceed the institutional cost limit for the waiver. If it does, the participant is denied entrance into the waiver, and is offered an opportunity to request a Fair Hearing by letter. The participant is also provided information on other service options, including the Adult Developmental Disabilities Waiver if the injury occurred before the age of 21; the Long Term Care Waiver; an acquired brain injury program housed on the campus of the ICF/ID institution; or a nursing home.

If the additional funding being requested does not exceed the institutional cost limit, the request is evaluated by the Division"s Extraordinary Care Committee, which has the authority to evaluate and approve requests for additional funding above a participant's individualized budget amount due to a material change in circumstance, a potential emergency or other condition justifying an increase in funding. The Extraordinary Care Committee's membership includes the Waiver Manager, a Fiscal Manager, and a representative from the State Medicaid Agency. The committee reviews information compiled by the participant's case manager that details the reasons for the need for increased funding, including specific health and welfare needs that are not able to be adequately addressed within the individualized budgeted amount.

c. Participant Safeguards. When the State specifies an individual cost limit in Item B-2-a and there is a change in the participant's condition or circumstances post-entrance to the waiver that requires the provision of services in an amount that exceeds the cost limit in order to assure the participant's health and welfare, the State has established the following safeguards to avoid an adverse impact on the participant *(check each that applies)*:

- ☑ **The participant is referred to another waiver that can accommodate the individual's needs.**
- ☑ **Additional services in excess of the individual cost limit may be authorized.**

Specify the procedures for authorizing additional services, including the amount that may be authorized:

When a funding opportunity is available or a person who qualifies for a reserved capacity slot, BHD completes an assessment of the individual's assessed needs based upon a combination of the ICAP, living arrangement, age, and other possible service needs to assign the individual budget amount. Using a person-centered approach, the participant, case manager and plan of care team work together to develop a plan of care that will allocate money from the budget for waiver services. The plan of care also identifies non-waiver services and supports needed by the participant. If the participant and/or guardian with support from the plan of care team identifies that the services needed are in excess of the budgeted amount, the case manager must submit a Budget Review Questionnaire to the Division for review.
If the assessed need for services above the assigned IBA is verified by the Division, then the individual's budget may be temporarily increased above the individual cost limit for the waiver and reviewed on an annual basis.
BHD will assigns the clinical review team (CRT) to stay involved in overseeing services, progress, and outcomes for the person. The CRT will work with the case manager and participant's team on transitioning the person into a lower budget over time that still meets the person's needs, into other appropriate services available while assuring the person's health and safety, or refer the person to other programs in the state for which they are eligible.
For significant changes in the health or welfare needs of a participant that require a permanent or long term increase in funding above the institutional cost limit for the waiver, the assessed need budget may be approved by the Division's Clinical Review Team or Extraordinary Care Committee. The Division will also work with the participant's team on other treatment, behavior or medical support services, and other service options to try to improve the person's condition and lower the cost of services over a two to three year period.

Notification of any budget reductions includes a referral to other state services or waiver for which the participant is likely eligible and the participant is also offered an opportunity to request a Fair Hearing.

Other safeguard(s)

Specify:

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (1 of 4)

a. Unduplicated Number of Participants. The following table specifies the maximum number of unduplicated participants who are served in each year that the waiver is in effect. The State will submit a waiver amendment to CMS to modify the number of participants specified for any year(s), including when a modification is necessary due to legislative appropriation or another reason. The number of unduplicated participants specified in this table is basis for the cost-neutrality calculations in Appendix J:

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	240
Year 2	240
Year 3	240
Year 4	240
Year 5	240

b. Limitation on the Number of Participants Served at Any Point in Time. Consistent with the unduplicated number of participants specified in Item B-3-a, the State may limit to a lesser number the number of participants who will be served at any point in time during a waiver year. Indicate whether the State limits the number of participants in this way: *(select one)*:

- **The State does not limit the number of participants that it serves at any point in time during a waiver year.**
- **The State limits the number of participants that it serves at any point in time during a waiver year.**

The limit that applies to each year of the waiver period is specified in the following table:

Table: B-3-b

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	
Year 2	
Year 3	
Year 4	
Year 5	

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

c. Reserved Waiver Capacity. The State may reserve a portion of the participant capacity of the waiver for specified purposes (e.g., provide for the community transition of institutionalized persons or furnish waiver services to individuals experiencing a crisis) subject to CMS review and approval. The State *(select one)*:

- **Not applicable. The state does not reserve capacity.**
- **The State reserves capacity for the following purpose(s).**

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (3 of 4)

d. Scheduled Phase-In or Phase-Out. Within a waiver year, the State may make the number of participants who are served subject to a phase-in or phase-out schedule *(select one)*:

- **The waiver is not subject to a phase-in or a phase-out schedule.**
- **The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an intra-year limitation on the number of participants who are served in the waiver.**

e. Allocation of Waiver Capacity.

Select one:

- **Waiver capacity is allocated/managed on a statewide basis.**
- **Waiver capacity is allocated to local/regional non-state entities.**

Specify: (a) the entities to which waiver capacity is allocated; (b) the methodology that is used to allocate capacity and how often the methodology is reevaluated; and, (c) policies for the reallocation of unused capacity among local/regional non-state entities:

f. Selection of Entrants to the Waiver. Specify the policies that apply to the selection of individuals for entrance to the waiver:

When there is sufficient funding, individuals are admitted to the waiver upon completion of the clinical and financial eligibility process.

Per Wyoming Medicaid rules, Chapter 43, Section 13, when there is insufficient funding to add additional participants, the DD Division maintains one waiting list for the ABI Waiver as specified below.

The DD Division assigns two rankings to each person on the waiting list based on the following two factors:

1) The severity of the person's condition based on the Inventory for Client and Agency Planning(ICAP)
2) The person's placement date on the waiting list.

When covered services become available, the DD Division alternates between the two factors beginning with the waiting list based on severity, in selecting the next person to whom covered services shall be provided.

In cases when the severity levels are the same or when the placement date on the waiting list is the same, the DD Division uses the date that the Case Management Selection form was received by the DD Division to determine which name goes first on the waiting list.

The DD Division determines the availability of funding for the approved individualized budget amounts for applicants on the waiting lists waiting for funding opportunities.

The DD Division can also fund a person from the ABI Waiver waiting list if it is determined he or she is in an emergency situation, such as homelessness or loss of primary caregiver. The DD Division, through the Extraordinary Care Committee (ECC) has established criteria to determine if a situation is an emergency,and reviews pertinent information to determine if the situation meets the emergency criteria.

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served - Attachment #1 (4 of 4)

Answers provided in Appendix B-3-d indicate that you do not need to complete this section.

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

a. 1. State Classification. The State is a *(select one)*:

- **§1634 State**
- **SSI Criteria State**
- **209(b) State**

2. Miller Trust State.
Indicate whether the State is a Miller Trust State *(select one)*:

- ○ **No**
- ◉ **Yes**

b. Medicaid Eligibility Groups Served in the Waiver. Individuals who receive services under this waiver are eligible under the following eligibility groups contained in the State plan. The State applies all applicable federal financial participation limits under the plan. *Check all that apply*:

Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR §435.217)

- ☑ **Low income families with children as provided in §1931 of the Act**
- ☑ **SSI recipients**
- ☐ **Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121**
- ☐ **Optional State supplement recipients**
- ☐ **Optional categorically needy aged and/or disabled individuals who have income at:**

Select one:

- ○ **100% of the Federal poverty level (FPL)**
- ○ **% of FPL, which is lower than 100% of FPL.**

Specify percentage:

- ☐ **Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII)) of the Act)**
- ☑ **Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)**
- ☐ **Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)**
- ☐ **Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)**
- ☐ **Medically needy in 209(b) States (42 CFR §435.330)**
- ☐ **Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)**
- ☐ **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver)**

Specify:

Special home and community-based waiver group under 42 CFR §435.217) *Note: When the special home and community-based waiver group under 42 CFR §435.217 is included, Appendix B-5 must be completed*

- ○ **No. The State does not furnish waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.** *Appendix B-5 is not submitted.*
- ◉ **Yes. The State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.**

Select one and complete Appendix B-5.

- ○ **All individuals in the special home and community-based waiver group under 42 CFR §435.217**
- ◉ **Only the following groups of individuals in the special home and community-based waiver group under 42 CFR §435.217**

Check each that applies:

- ☑ **A special income level equal to:**

Select one:

- ◉ **300% of the SSI Federal Benefit Rate (FBR)**
- ○ **A percentage of FBR, which is lower than 300% (42 CFR §435.236)**

Specify percentage:

- ○ **A dollar amount which is lower than 300%.**

Specify dollar amount:

- ☐ **Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)**
- ☐ **Medically needy without spenddown in States which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)**
- ☐ **Medically needy without spend down in 209(b) States (42 CFR §435.330)**
- ☐ **Aged and disabled individuals who have income at:**

Select one:

100% of FPL

% of FPL, which is lower than 100%.

Specify percentage amount:

Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver)

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (1 of 7)

In accordance with 42 CFR §441.303(e), Appendix B-5 must be completed when the State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR §435.217 group.

a. Use of Spousal Impoverishment Rules. Indicate whether spousal impoverishment rules are used to determine eligibility for the special home and community-based waiver group under 42 CFR §435.217:

Note: For the five-year period beginning January 1, 2014, the following instructions are mandatory. The following box should be checked for all waivers that furnish waiver services to the 42 CFR §435.217 group effective at any point during this time period.

Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the State uses *spousal* post-eligibility rules under §1924 of the Act.
Complete Items B-5-e (if the selection for B-4-a-i is SSI State or §1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time periods before January 1, 2014 or after December 31, 2018.

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018 (select one).

Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group.

In the case of a participant with a community spouse, the State elects to (*select one*):

Use spousal post-eligibility rules under §1924 of the Act.
(Complete Item B-5-b (SSI State) and Item B-5-d)

Use regular post-eligibility rules under 42 CFR §435.726 (SSI State) or under §435.735 (209b State)
(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The State uses regular post-eligibility rules for individuals with a community spouse.
(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (2 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

b. Regular Post-Eligibility Treatment of Income: SSI State.

The State uses the post-eligibility rules at 42 CFR 435.726. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant (*select one*):

The following standard included under the State plan

Select one:

SSI standard

Optional State supplement standard

Medically needy income standard

The special income level for institutionalized persons

(*select one*):

300% of the SSI Federal Benefit Rate (FBR)

A percentage of the FBR, which is less than 300%

Specify the percentage:

A dollar amount which is less than 300%.

Specify dollar amount:

A percentage of the Federal poverty level

Specify percentage:

Other standard included under the State Plan

Specify:

The following dollar amount

Specify dollar amount: If this amount changes, this item will be revised.

The following formula is used to determine the needs allowance:

Specify:

The maintenance needs allowance is equal to the individual's total income as determined under the post-eligibility process which includes income that is placed in a Miller trust.

Other

Specify:

ii. Allowance for the spouse only (*select one*):

Not Applicable (see instructions)
SSI standard
Optional State supplement standard
Medically needy income standard
The following dollar amount:

Specify dollar amount: If this amount changes, this item will be revised.

The amount is determined using the following formula:

Specify:

iii. Allowance for the family (*select one*):

Not Applicable (see instructions)
AFDC need standard
Medically needy income standard
The following dollar amount:

Specify dollar amount: The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.

The amount is determined using the following formula:

Specify:

Other

Specify:

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:

a. Health insurance premiums, deductibles and co-insurance charges
b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses.

Select one:

- **Not Applicable (see instructions)***Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.*
- **The State does not establish reasonable limits.**
- **The State establishes the following reasonable limits**

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (3 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

c. Regular Post-Eligibility Treatment of Income: 209(B) State.

Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (4 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules

The State uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care if it determines the individual's eligibility under §1924 of the Act. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the State Medicaid Plan. The State must also protect amounts for incurred expenses for medical or remedial care (as specified below).

Answers provided in Appendix B-5-a indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (5 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

e. Regular Post-Eligibility Treatment of Income: §1634 State - 2014 through 2018.

Answers provided in Appendix B-5-a indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (6 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

f. Regular Post-Eligibility Treatment of Income: 209(B) State - 2014 through 2018.

Answers provided in Appendix B-5-a indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (7 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

g. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules - 2014 through 2018.

The State uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the State Medicaid Plan. The State must also protect amounts for incurred expenses for medical or remedial care (as specified below).

Answers provided in Appendix B-5-a indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

As specified in 42 CFR §441.302(c), the State provides for an evaluation (and periodic reevaluations) of the need for the level(s) of care specified for this waiver, when there is a reasonable indication that an individual may need such services in the near future (one month or less), but for the availability of home and community-based waiver services.

a. Reasonable Indication of Need for Services. In order for an individual to be determined to need waiver services, an individual must require: (a) the provision of at least one waiver service, as documented in the service plan, and (b) the provision of waiver services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the service plan. Specify the State's policies concerning the reasonable indication of the need for services:

i. Minimum number of services.

The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is: 1

ii. Frequency of services. The State requires (select one):

- (•) **The provision of waiver services at least monthly**
- ( ) **Monthly monitoring of the individual when services are furnished on a less than monthly basis**

If the State also requires a minimum frequency for the provision of waiver services other than monthly (e.g., quarterly), specify the frequency:

b. Responsibility for Performing Evaluations and Reevaluations. Level of care evaluations and reevaluations are performed (*select one*):

- (•) **Directly by the Medicaid agency**
- ( ) **By the operating agency specified in Appendix A**
- ( ) **By an entity under contract with the Medicaid agency.**

Specify the entity:

- ( ) **Other**

Specify:

c. Qualifications of Individuals Performing Initial Evaluation: Per 42 CFR §441.303(c)(1), specify the educational/professional qualifications of individuals who perform the initial evaluation of level of care for waiver applicants:

The Division performs the initial level of care evaluation for waiver applicants. Division staff performing the initial level of care evaluation are required to have any combination of training and experience equivalent to a bachelor's degree in business or public administration, social services, psychology, counseling or education, PLUS two years of professional work experience in training, counseling, planning or administering services for persons in a brain injury, developmental disability program or a visually impaired program.

d. Level of Care Criteria. Fully specify the level of care criteria that are used to evaluate and reevaluate whether an individual needs services through the waiver and that serve as the basis of the State's level of care instrument/tool. Specify the level of care instrument/tool that is employed. State laws, regulations, and policies concerning level of care criteria and the level of care instrument/tool are available to CMS upon request through the Medicaid agency or the operating agency (if applicable), including the instrument/tool utilized.

If a person has medical verification of the an acquired brain injury that is approved by the Division, then three tools are used to determine ICF/IID Level of Care for initial applicants: the LT-104 form, a neuropsychological evaluation, and an Inventory for Client and Agency Planning (ICAP) assessment.

LT-104 Form
First, the LT-104 form assesses the individual's qualifying conditions for ICF/IID level of care due to medical or psychological criteria and functional limitations. The LT-104 indicates the person has or a developmental disability and may meet the ICF/IID level of care based upon needs in at least two of the following areas:

1) Medical criteria, where the person requires daily monitoring due to his/her medical condition and overall care planning is necessary and/or supervision is needed due to medication effects,

Or the individual meets:

2) Psychological criteria, where the person requires supervision due to impaired judgment, limited capabilities, behavior, abusiveness, assaultiveness, and/or psychotropic drug effects.

After meeting at least one of the criteria (#1 or #2) above, the individual must also have:

3) Functional limitations, where the person requires assistance with activities of daily living, self-help skills, ambulation, mobility, routine incontinence care, catheter care, ostomy, and/or a structured and safe environment that provides supervision as needed to remain safe.

If the individual is determined to meet the criteria on the LT-104 form, then the assessment indicates the individual requires the provision of waiver services monthly to develop skills necessary for maximum independence and/or the prevention of regression or loss of current skills/abilities.

Neuropsychological evaluation
The neuropsychological evaluation shall provide verification that the individual meets ICF/IID level of care through the following:
1) A Mayo Portland Adaptability Inventory (MPAI) score of 42 or more
or
2) A California Verbal Learning Test II Trials 1-5 T score of 40 or less
or
3) Supervision Rating Scale score of 4 or more

ICAP
The Inventory for Client and Agency Planning (ICAP) assessment is completed to measure the severity of the functional limitations for ICF/IID level of care determination. The individual shall have an ICAP service score of 70 or less.

e. Level of Care Instrument(s). Per 42 CFR §441.303(c)(2), indicate whether the instrument/tool used to evaluate level of care for the waiver differs from the instrument/tool used to evaluate institutional level of care *(select one)*:

- (●) **The same instrument is used in determining the level of care for the waiver and for institutional care under the State Plan.**
- ( ) **A different instrument is used to determine the level of care for the waiver than for institutional care under the State plan.**

Describe how and why this instrument differs from the form used to evaluate institutional level of care and explain how the outcome of the determination is reliable, valid, and fully comparable.

f. Process for Level of Care Evaluation/Reevaluation: Per 42 CFR §441.303(c)(1), describe the process for evaluating waiver applicants for their need for the level of care under the waiver. If the reevaluation process differs from the evaluation process, describe the differences:

Initial Evaluation:

The Division first requires medical verification of an acquired brain injury before assessing the person's level of care. Verification of a brain injury is determined by a licensed physician and registered nurse who reviews the medical documentation submitted by the applicant and verifies that this documentation meets the definition of acquired brain injury as listed below:

Acquired Brain Injury - any combination of focal and diffuse central nervous system dysfunction. Both immediate and/or delayed, at the brain stem level and above. These dysfunctions are acquired through the interaction of any external forces and the body, oxygen deprivation, infection, toxicity, surgery and vascular disorders not associated with aging. It is an injury to the brain that has occurred since birth. It may have been caused by an external physical force or by a metabolic disorder(s). The term acquired brain injury includes traumatic brain injuries such as open or closed head injuries and non traumatic brain injuries such as those caused by strokes, tumors, infectious diseases (e.g. encephalitis or meningitis), hypoxic injuries (e.g. asphyxiation, near drowning, anesthetic incidents, or severe blood loss), metabolic disorders (e.g., insulin shock or liver or kidney disease), and toxic products taken into the body through inhalation or ingestion. The term does not include brain injuries that are congenital or brain injuries induced by birth trauma. These dysfunctions are not developmental or degenerative.

If a person has medical verification of the an acquired brain injury that is approved by the Division, then three tools are used to determine ICF/IID Level of Care for initial applicants: the LT-MR-104 form, a neuropsychological evaluation, and an Inventory for Client and Agency Planning (ICAP) assessment.

First, the LT-104 form assesses the individual's qualifying conditions for ICF/IID level of care due to medical or psychological criteria and functional limitations. The LT-104 indicates the person has a developmental disability and may meet the ICF/IID level of care based upon needs in at least two of the following areas:

1) Medical criteria, where the person requires daily monitoring due to his/her medical condition and overall care planning is necessary and/or supervision is needed due to medication effects,

Or the individual meets:

2) Psychological criteria, where the person requires supervision due to impaired judgment, limited capabilities, behavior, abusiveness, assaultiveness, and/or psychotropic drug effects.

After meeting at least one of the criteria (#1 or #2) above, the individual must also have:

3) Functional limitations, where the person requires assistance with activities of daily living, self-help skills, ambulation, mobility, routine incontinence care, catheter care, ostomy, and/or a structured and safe environment that provides supervision as needed to remain safe.

If the individual is determined to meet the criteria on the LT-104 form, then the assessment indicates the individual requires the provision of waiver services monthly to develop skills necessary for maximum independence and/or the prevention of regression or loss of current skills/abilities.

If the individual is determined to meet the criteria above, a neuropsychological evaluation is authorized to be completed by a licensed psychologist, who has at least one year of post doctoral work in acquired brain injury. The neuropsychological evaluation shall provide verification that the individual meets ICF/IID level of care through the following:

1) A Mayo Portland Adaptability Inventory (MPAI) score of 42 or more
or
2) A California Verbal Learning Test II Trials 1-5 T score of 40 or less
or
3) Supervision Rating Scale score of 4 or more

A determination of either #1, 2, or 3 must be found to qualify for ICF/IID level of care and to have the third assessment (ICAP) completed.

If the individual meets one of the conditions in the neuropsychological evaluation, then an Inventory for Client and Agency Planning (ICAP) assessment is completed to measure the severity of the functional limitations for ICF/IID level of care determination. The individual shall have an ICAP service score of 70 or less.

If the individual meets the criteria as verified through these three assessment tools, the Division determines that the individual meets ICF/IID Level of Care.

Reevaluation process:

The reevaluation process includes the annual level of care assessment using the LT-104, which determines that the person continues to meet the level of care for the ICF/IID. The other two tools, the neuropsychological evaluation and the ICAP assessment, are completed and evaluated by the Division every five years or as needed because of a change in the person's condition.

g. Reevaluation Schedule. Per 42 CFR §441.303(c)(4), reevaluations of the level of care required by a participant are conducted no less frequently than annually according to the following schedule *(select one)*:

- ○ **Every three months**
- ○ **Every six months**
- ◉ **Every twelve months**
- ○ **Other schedule**

Specify the other schedule:

h. Qualifications of Individuals Who Perform Reevaluations. Specify the qualifications of individuals who perform reevaluations *(select one)*:

- ◉ **The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.**
- ○ **The qualifications are different.**

Specify the qualifications:

i. Procedures to Ensure Timely Reevaluations. Per 42 CFR §441.303(c)(4), specify the procedures that the State employs to ensure timely reevaluations of level of care *(specify):*

In Chapter 43, Section 9 of the Wyoming Medicaid rules, rules for the Acquired Brain Injury Waiver, the Division requires annual submission of level of care assessment and the plan of care from the individual's case manager. These items are required to be submitted 30 days prior to the plan start date, so the Division within the State Medicaid Agency can determine level of care based upon recommendations by the case manager before services are authorized.

The Division reviews a level of care assessment to assure it meets the eligibility requirements as detailed in B.6.f. and has been completed within the required time frames. Level of care assessments must be completed annually, which is no more than 365 days from the last level of care evaluation date. The case managers' submission of the annual level of care assessment to the Division is tracked through the Electronic Medicaid Waiver System (EMWS). A report is generated for the level of care determinations that are due within the next 30 days, which have not been submitted to the Division by the case manager. The case manager is notified by the Division in writing of the requirement to submit the level of care form within seven (7) business days. Once the level of care form is received, Division staff complete the level of care determination and enter the date that the redetermination was completed and the results of the redetermination. In instances, where assessments are not reevaluated within the required time frames, the Division tracks the concern and notifies the case manager that an evaluation is needed for continued eligibility. If expired assessments are identified as a concern with a provider, then the Division will require a quality improvement plan from the provider to ensure timeliness of continued eligibility assessments.

j. Maintenance of Evaluation/Reevaluation Records. Per 42 CFR §441.303(c)(3), the State assures that written and/or electronically retrievable documentation of all evaluations and reevaluations are maintained for a minimum period of 3 years as required in 45 CFR §92.42. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:

Maintenance of these records is required by the providers of case management. The case manager and the Division will maintain all documentation relevant to evaluations and reevaluations for a minimum of 6 years.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Level of Care Assurance/Sub-assurances

The state demonstrates that it implements the processes and instrument(s) specified in its approved waiver for evaluating/reevaluating an applicant's/waiver participant's level of care consistent with level of care provided in a hospital, NF or ICF/IID.

i. Sub-Assurances:

a. ***Sub-assurance: An evaluation for LOC is provided to all applicants for whom there is reasonable indication that services may be needed in the future.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
7 Percentage of applicants who had a Level of Care assessment conducted prior to eligibility determination (the number of applicants who completed or did not complete the LOC assessment process divided by the number of applicants.)

Data Source (Select one):
Other
If 'Other' is selected, specify:
Electronic Medicaid Waiver System (EMWS)

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other**	☐ **Annually**	☐ **Stratified**

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis *(check each that applies):*
Specify:	Describe Group:
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:
	☐ **Other** Specify:

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: The levels of care of enrolled participants are reevaluated at least annually or as specified in the approved waiver.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
8 Percentage of annual level of care assessments conducted timely for each participant (the number of annual LOC assessments completed timely divided by the total number of waiver participants.)

Data Source (Select one):
Other
If 'Other' is selected, specify:
EMWS

Responsible Party for data collection/generation *(check each that applies):*	Frequency of data collection/generation *(check each that applies):*	Sampling Approach *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis *(check each that applies):*	
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. ***Sub-assurance: The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant level of care.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
9 Percentage of annual Level of Care assessments conducted for each eligible participant in accordance with Division standards and the approved waiver (the number of annual LOC assessments conducted in accordance with state standards and the approved waiver divided by the total number of active participants)

Data Source (Select one):
Other
If 'Other' is selected, specify:
EMWS

Responsible Party for data collection/generation *(check each that applies):*	Frequency of data collection/generation *(check each that applies):*	Sampling Approach *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*	
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

For Subassurance a:
Responsible Party*(check each that applies):* **Frequency of data aggregation and analysis***(check each that applies):*
The level of care (LOC) assessment is submitted by the targeted case manager for determination by BHD. If a case manager fails to submit the LT-104 within 30 days of becoming the applicant's case manager, BHD staff notifies the case manager of the requirement to submit the information. An application is considered complete once the applicant has completed the application form for the waiver, uploaded guardianship papers (if applicable) and has a completed case management selection form signed by the case manager chosen. If the case manager submits an LT-104 form that is incomplete or not accurate, BHD requires the correction of the form and tracks this information in the EMWS.

BHD tracks the dates of each stage of eligibility in a database and follows up with the case manager if the next steps in eligibility are not taken in according to Division rules. The psychological evaluation is due within 60 days of a case manager being chosen, unless there are problems with finding a psychologist with an appointment available or there is a delay in the report, in which case, an extra 30 days is allotted. After the psychological evaluation is approved by BHD, the ICAP assessment shall be completed within 30 days of the request being submitted to the contractor. If the ICAP is not completed according to the timeframe specified in the contract, BHD follows up with the contractor to ensure timeliness in subsequent assessments completed. BHD determines level of care based on the three assessments and tracks the determination in EMWS, so the number of level of care determinations and results of the determinations can be quantified.

For Subassurance b:
A report is generated for the level of care redeterminations due within the next 30 days that have not been submitted to the Division by the case manager. The case manager is notified by the Division in EMWS of the requirement to submit the level of care assessment information, if there is a lapse in the LOC due date. If late submissions continue to be a problem with a certain case manager, then a corrective action plan is issued with the case manager to address the certification concern.

When case managers submit level of care assessments for approval by BHD that are incomplete or inaccurate, they are required to correct it and resubmit it to BHD. If problems with the LOC persist, BHD tracks the problem as a certification issue and retrain the case manager on the level of care tool to address the problem.

The case manager may also be required to complete a Corrective Action Plan as described in Appendix G.

For Subassurance c:The level of care assessment submitted to BHD in the EMWS by the case manager is accompanied with required assessments listed in the waiver, which are the psychological evaluation and the ICAP assessment. If the ICAP assessment date is outside the required timeframe, the case manager is immediately notified and testing is scheduled. If a participant is determined by BHD to not meet ICF/IID Level Of Care or becomes ineligible because of one the required assessments, then an adverse action letter will be sent to the participant and case manager to notify them of the denial of eligibility of the waiver and the participant's right to a fair hearing.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Level of Care that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Level of Care, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

Freedom of Choice. *As provided in 42 CFR §441.302(d), when an individual is determined to be likely to require a level of care for this waiver, the individual or his or her legal representative is:*

i. informed of any feasible alternatives under the waiver; and
ii. given the choice of either institutional or home and community-based services.

a. Procedures. Specify the State's procedures for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver and allowing these individuals to choose either institutional or waiver services. Identify the form(s) that are employed to document freedom of choice. The form or forms are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

When a person applies for the ABI Waivers, BHD staff talk to the waiver applicant in person or by telephone to explain the application process and to provide information on waivers and institutional services available, so the applicant can make an informed choice of institution or community-based services. BHD staff also give the BHD waiver overview and application guide to the applicant in person or by mail along with the contact information for BHD and other available resources in the state. This guide includes written information stating the applicant has a choice of waiver or institutional services. Applicants sign the application stating they understand they have a choice of institutional or community based services. After completing the application the applicant chooses a targeted case manager who coordinates completion of the assessments needed to determine the person meets the targeting criteria and ICF/IID level of care. Once the applicant is presumed eligible, he or she can choose to pursue services at the institution or on the waiver. If the applicant chooses the institution, the targeted case manager assists the applicant in completing the process for applying at the institution.

b. Maintenance of Forms. Per 45 CFR §92.42, written copies or electronically retrievable facsimiles of Freedom of Choice forms are maintained for a minimum of three years. Specify the locations where copies of these forms are maintained.

This is a component part of case management. The case manager and the Division will maintain all freedom of choice forms for a minimum of 6 years.

Appendix B: Participant Access and Eligibility

B-8: Access to Services by Limited English Proficiency Persons

Access to Services by Limited English Proficient Persons. Specify the methods that the State uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):

BHD utilizes an interpreter service provider, which is used by the State Medicaid Agent for other Medicaid beneficiaries. If needed, Case Managers complete a request form for interpreter services for a language of their choice and specify the materials that need translated, then specify whether the translation is needed in written form, verbally, or both. Individual Plans of Care or other waiver materials can be translated into another language upon request. If there is a significant number of beneficiaries requesting written materials in a language different than English, the BHD contracts to have printed materials in different languages.

Appendix C: Participant Services

C-1: Summary of Services Covered (1 of 2)

a. Waiver Services Summary. *List the services that are furnished under the waiver in the following table. If case management is not a service under the waiver, complete items C-1-b and C-1-c:*

Service Type	Service		
Statutory Service	Adult Day Services		
Statutory Service	Case Management		
Statutory Service	Community Integration Services		
Statutory Service	Homemaker		
Statutory Service	Personal Care		
Statutory Service	Prevocational Services		
Statutory Service	Residential Habilitation		
Statutory Service	Respite		
Statutory Service	Supported Employment		
Statutory Service	Supported Living		
Extended State Plan Service	Occupational Therapy		
Extended State Plan Service	Physical Therapy		
Extended State Plan Service	Speech, Hearing and Language Services		
Supports for Participant Direction	Independent Support Broker		
Other Service	Behavioral Support Services		
Other Service	Cognitive Retraining		
Other Service	Companion Services		
Other Service	Crisis Intervention Support		
Other Service	Dietician Services		
Other Service	Environmental Modifications		
Other Service	Self-Directed Goods and Services		
Other Service	Skilled Nursing		
Other Service	Specialized Equipment		
Other Service	Transportation		

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Adult Day Health

Alternate Service Title (if any):

Adult Day Services

HCBS Taxonomy:

Category 1:

04 Day Services

Sub-Category 1:

04050 adult day health

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service

Category 4:

Sub-Category 4:

Definition *(Scope):*

Adult Day Services are structured services consisting of meaningful day activities that maximize or maintain skills and abilities, keep participants engaged in their environment and community through optimal care and support; actively stimulate, encourage, develop, maintain, personal skills; introduce new leisure pursuits, establish new relationships, improve or maintain flexibility, mobility, and strength; or build on previously learned skills.

Adult Day Services provide active supports which foster independence, are person-centered to the maximum extent possible, as identified in the participant's plan of care. Adult Day services also include personal care, protective oversight, and health maintenance activities such as medication assistance and routine activities that may be provided by unlicensed direct support professionals identified in the plan of care.

Adult Day Services are usually provided in a congregate setting. When provided in congregate community setting, there must be staff on-site within immediate proximity to allow staff to provide support and supervision, safety and security, and provide activities to keep the person engaged in their environment.

Transportation into the community to shop, attend recreational and civic events, or other community activities and resources, is a component of Adult Day Services and is included in the rate to providers.

A Participant receives a tiered service approved in the plan of care based upon need, according to the following tiers descriptions:

Basic Level of Care
Levels 1 and 2 on the Level of Service Need grid will generally be in this tier. Service tier requires limited staff supports and personal attention to a participant daily due to a moderately high level of independence and functioning. Behavioral needs, if any, can be met with medication or informal direction by staff. The person may have periods of time with indirect staff supervision where staff are onsite and available through hearing distance of a request.

Intermediate Level of Care
Levels 3 and 4 on the Level of Service Need grid will generally be in this tier. Service tier requires full-time supervision with staff available on-site within line of sight due to significant functional limitations, medical and/or behavioral needs. Behavioral and medical supports are not generally intense and can be provided in a shared staffing setting. Regular personal attention is given throughout the day for personal care, reinforcement, community or social activities.

High Level of Care
Levels 5 and 6 on the Level of Service Need grid will generally be in this tier. Service tier requires full-time supervision with staff available on-site within absolute line of sight and frequent staff interaction and personal attention for significant functional limitations, medical and/or behavioral needs. Support and supervision needs are moderately intense, but can still generally be provided in a shared setting unless otherwise specified in the plan of care. Frequent personal attention given throughout the day for reinforcement, positive behavior support, personal care, community or social activities.

Transportation services in the waiver is not intended to cover activities on a person's Adult day service schedule where the provider is part of the activity. Transportation services on the waiver can be used if a person in Adult Day services wants to go to an activity outside of their normal schedule and if the provider is not a part of the activity. It is a stop gap service, so the person can get a ride, but does not have to pay for the provider to be with them for a "service" other than the ride.

The rate for Adult Day services includes the cost of routine transportation.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Provider Category: Provider Type Title

Adult Day Services are not a habilitation service. Service units will be based on individual level of support need and must fit within the assigned budget. Adult Day Services focus on enabling the participant to attain or maintain his or her maximum functional level and shall be coordinated with any physical, occupational, or speech therapies in the service plan. Services may serve to reinforce skills or lessons taught in other settings.

Individuals in Adult Day Services may not be paid for work activities performed during this service.

Personal care is included in this service and therefore stand-alone personal care is not permitted during the delivery of this service.

Participants who receive this service may also receive Community Integration services, Supported Employment and Prevocational services. A participant's service plan may include two or more types of non-residential habilitation services as long as service times do not overlap.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)*:

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Licensed Adult Day Care
Agency	Agency certified by BHD to provide Adult Day Services
Agency	CARF-accredited agency also certified by BHD for Adult Day Services

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Adult Day Services

Provider Category:
Agency

Provider Type:
Licensed Adult Day Care

Provider Qualifications

License *(specify)*:
A license for an Adult Day Care as provided by the State of Wyoming, Office of licensing and survey.

Certificate *(specify)*:
Any provider of this service is required to attain and maintain a certification for this service from the Wyoming Department of Health, Behavioral Health Division.

Other Standard *(specify)*:
An agency providing this service must meet the requirements in Wyoming Medicaid rules, Chapter 45, including assuring any employee providing this service successfully passes a Criminal History Background check, attains and maintains current CPR and First Aid Certification for all direct care staff, has employees certified in Medication Assistance for participants who need help with medications, has employees certified in crisis intervention and restraint usage(such as CPI or Mandt) if provider is serving participants with those possible needs, and has documentation on file that any employee in the agency transporting a participant has a current driver's license and automobile insurance. Agency direct care staff must also complete and document participant specific training before serving a participant, and complete and document general trainings on recognizing abuse and neglect, incident reporting, complaint process requirements, documentation standards, participant rights and rights restrictions, implementing the participant's objectives, and HIPAA & confidentiality requirements.

The Agency must adhere to the standards and requirements specified in Wyoming Medicaid Rules Chapter 45 and also meet all other the applicable Medicaid rules and regulations specified in the BHD Provider manual and provider agreement.

Verification of Provider Qualifications

Entity Responsible for Verification:
Behavioral Health Division

Frequency of Verification:

The Division initially certifies a new agency providing this service for one year and the agency is required to complete a recertification every year thereafter for the provision of this service. The Division has the authority to monitor agencies throughout their recertification period through the complaint process, incident reporting process, or internal referral process if there is indication the provider is not complying with the rules and regulations.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Adult Day Services

Provider Category:

Agency

Provider Type:

Agency certified by BHD to provide Adult Day Services

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Any provider of this service is required to attain and maintain a certification for this service from the Wyoming Department of Health, Behavioral Health Division.

Other Standard *(specify):*

An agency providing this service must meet the requirements in Wyoming Medicaid rules, Chapter 45, including assuring any employee providing this service successfully passes a Criminal History Background check, attains and maintains current CPR and First Aid Certification for all direct care staff, has employees certified in Medication Assistance for participants who need help with medications, has employees certified in crisis intervention and restraint usage(such as CPI or Mandt) if provider is serving participants with those possible needs, and has documentation on file that any employee in the agency transporting a participant has a current driver's license and automobile insurance. Agency direct care staff must also complete and document participant specific training before serving a participant, and complete and document general trainings on recognizing abuse and neglect, incident reporting, complaint process requirements, documentation standards, participant rights and rights restrictions, implementing the participant's objectives, and HIPAA & confidentiality requirements.

The Agency must adhere to the standards and requirements specified in Wyoming Medicaid Rules Chapter 45 and also meet all other the applicable Medicaid rules and regulations specified in the BHD Provider manual and provider agreement.

For parent/stepparents provider agencies serving their child on the waiver, the agency shall become a certified Medicaid Waiver provider and an Limited Liability Company or a Corporation by the passage of House Enrolled Act 91 effective July 1, 2011.

Verification of Provider Qualifications

Entity Responsible for Verification:

Behavioral Health Division

Frequency of Verification:

The Division initially certifies a new agency providing this service for one year and the agency is required to complete a recertification every year thereafter for the provision of this service. The Division has the authority to monitor agencies throughout their recertification period through the complaint process, incident reporting process, or internal referral process if there is indication the provider is not complying with the rules and regulations.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Adult Day Services

Provider Category:

Agency

Provider Type:

CARF-accredited agency also certified by BHD for Adult Day Services

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Any provider of this service is required to attain and maintain a certification for this service from the Wyoming Department of Health, Behavioral Health Division. BHD requires a provider to attain and maintain accreditation by the Commission on Accreditation of Rehabilitative Facilities (CARF) or other nationally recognized accreditation entity for human services as specified in Chapter 45 the Wyoming Medicaid rules.

Other Standard *(specify):*

An agency providing this service must meet the requirements in Wyoming Medicaid rules, Chapter 45, including assuring any employee providing this service successfully passes a Criminal History Background check, attains and maintains current CPR and First Aid Certification for all direct care staff, has employees certified in Medication Assistance for participants who need help with medications, has employees certified in crisis intervention and restraint usage(such as CPI or Mandt) if provider is serving participants with those possible needs, and has documentation on file that any employee in the agency transporting a participant has a current driver's license and automobile insurance. Agency direct care staff must also complete and document participant specific training before serving a participant, and complete and document general trainings on recognizing abuse and neglect, incident reporting, complaint process requirements, documentation standards, participant rights and rights restrictions, implementing the participant's objectives, and HIPAA & confidentiality requirements.

The Agency must adhere to the standards and requirements specified in Wyoming Medicaid Rules Chapter 45 and also meet all other the applicable Medicaid rules and regulations specified in the BHD Provider manual and provider agreement.

For parent/stepparents provider agencies serving their child on the waiver, the agency shall become a certified Medicaid Waiver provider and an Limited Liability Company or a Corporation by the passage of House Enrolled Act 91 effective July 1, 2011.

Verification of Provider Qualifications

Entity Responsible for Verification:

Behavioral Health Division

Frequency of Verification:

The Division initially certifies a new agency providing this service for one year and the agency is required to complete a recertification every year thereafter for the provision of this service. The Division has the authority to monitor agencies throughout their recertification period through the complaint process, incident reporting process, or internal referral process if there is indication the provider is not complying with the rules and regulations.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Case Management

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
01 Case Management	01010 case management
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Case management is a service to assist participants in gaining access to needed waiver and other Medicaid State Plan services, as well as medical, social, educational and other services, regardless of the funding source for the services to which access is gained.

Case managers are responsible for the following functions for participants choosing not to self-direct services:
• Assessment and/or reassessment of the need for waiver services;
• Initiating the process to evaluate and/or re-evaluate the individual's level of care
• Linking waiver participants to other Federal, state and local programs;
• Developing the plan of care according to the Division's policies and procedures;
• Coordinating multiple services and/or among multiple providers;
• Ongoing monitoring of the implementation of the plans of care;
• Ongoing monitoring of participant's health and welfare;
• Addressing problems in service provision, including problems found during the ongoing monitoring of the implementation of the plan of care or concerns with a participant's health and welfare;
• Responding to participant crises;
• Reviewing service utilization and documentation of all services provided on a monthly basis, including services of those participants who are self-directing some or all of the waiver services, to assure the amount, frequency, and duration of services are appropriate.

The case manager is required to complete the following responsibilities monthly:
• A home visit with the participant present to monitor the participant's health and welfare, as well as to discuss satisfaction with services and needed changes to the plan of care with the participant.
• Direct contact each month with participant and/or guardian, which must include the home visit but may also include observation of services to assess implementation of the plan of care, telephone contact with participant or guardian and/or meeting with the participant and/or guardian to complete follow up on concerns identified through incident reports, complaints or identified through other means.
• Follow-up on all concerns or questions raised by the participant, guardian or plan of care team or identified through incident reports, complaints or through observation of services.
• Review of service utilization and provider documentation of service, identify significant health changes, trends through incident reports, evaluate the use of restraints and restrictive interventions, interview participant and/or guardian on satisfaction with services, and complete follow-up on concerns identified in any of these processes.

Subsequent assessments are provided as part of ongoing case management and will include the necessary collaboration of professionals to assess the needs, characteristics, preferences and desires of the waiver participant. Case managers shall initiate and oversee subsequent assessments, regardless of payment source. These include the psychological assessment, if needed for continued eligibility, and any other assessments that are necessary to determine the participant's needs and are not available through the Medicaid State plan. All assessments shall be prior authorized by the Division.
****
Case Managers are responsible for the following functions for participants who choose to self-direct services:
• Assessment and/or reassessment of the need for waiver services;
• Initiating the process to evaluate and/or re-evaluate the individual's level of care
• Working with the participant, Support Broker and other team members on development of the plan of care that addresses the participant's needs, and submission of the plan of care to the Division adhering to the Division's policies and procedures;
• Ongoing monitoring of the implementation of the plan of care, including monitoring self-directed services and traditional services;
• Ongoing monitoring of participants' health and welfare;
• Addressing problems in service provision, including problems found during the ongoing monitoring of the implementation of the plan of care or concerns with a participant's health and welfare, working with the participant, Support Broker and plan of care team members as appropriate;
• Responding to participant crises;
• Reviewing service utilization and documentation of all services provided on a monthly basis, including all self-directed services, to assure the amount, frequency, and duration of services are appropriate.

The role of the Case Manager is to monitor the implementation of the individual plan of care and provide coordination and oversight of supports but not "hands on" involvement in identifying and securing supports. Those are duties of the Support Broker if there is one on the plan.

The case manager is required to complete the following monthly:
• A home visit with the participant present to monitor the participant's health and welfare, as well as to discuss satisfaction with services and needed changes to the plan of care with the participant.
• Direct contact each month with participant and/or guardian, which must include the home visit but may also include observation of services to assess implementation of the plan of care, telephone contact with participant or guardian and/or meeting with the participant and/or guardian to complete follow up on concerns identified through incident reports, complaints or identified through other means.
• Follow-up on all concerns or questions raised by the participant, guardian or plan of care team or identified through incident reports, complaints or through observation of services.
• Review of service utilization and provider documentation of service, identify significant health changes, trends through incident reports, evaluate the use of restraints and restrictive interventions, interview participant and/or guardian on satisfaction with services, and complete follow-up on concerns identified in any of these processes.

Some participants self-directing services may choose not to have a Support Broker. This may be because they are skilled enough to complete those tasks themselves (as determined through assessment) or they have natural supports that can assist them. In these cases, the general oversight responsibilities of the case manager shall be sufficient to monitor the participant's self-direction efforts.

_____
The Division has safeguards in place to assure that the service providers' influence on the planning process (including exercising free choice of providers, controlling the content of the plan, including assessment of risk, services, frequency and duration, and informing the participant of their rights) is a part of the plan of care verification/signature process before the plan is approved. The Division also has team meeting procedures for case managers to follow to ensure choice in providers, services, institutional care, and service delivery options are reviewed with the participant and legally authorized representative annually. The provider manual, Wyoming Medicaid Rules, Chapter 45, and the Division rules for case management also require the case manager to review choice, plan for services, risks, and one's goals without any undue influence from other providers or parties. The case manager is required to fully disclose any conflicts to the participant and who they can contact if there is a concern, including the process for filing a grievance or complaint with the state in order to get BHD involvement in the case.

In cases where there is evidence of unethical conduct or non-performance of duties, a referral is made to the Provider Support unit within the BHD to investigate the "complaint." If the complaint is substantiated, the case manager is required to complete a corrective action plan addressing the non-compliance with case management requirements.

Provider Category **Provider Type Title**

The signature page which concludes the plan of care has all parties signing the form confirm that the plan of care has been carefully planned and coordinated with the active involvement of the participant and guardian. The signatures also assure the plan has been individually tailored, identifying appropriate waiver and non-waiver services, and establishing schedules, activities, and objectives that incorporate the participant's unique needs and preferences. The plan specifically states "I have been present, encouraged, and involved at every possible level during the development of my plan of care," therefore, by signing the plan the participant or guardian verify their involvement in the development of the plan. The participant and guardian must also sign off if a conflict is disclosed, how the case manager addresses conflicts from an outside third party, and how the conflicts are mitigated whenever possible.

Case managers are required to have all relative providers complete and sign the BHD's Relative Disclosure and Safeguards Acknowledgement form. That form is then sent to the Division which is reviewed by a designated Division staff and signed off on for approval with a copy returned to the case manager. The case manager then uploads a copy of the approved form into the Electronic Medicaid Waiver System with the Plan of Care information. Case managers and relative providers must disclose any conflicts or relationships to the participant's team.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Case Managers shall be reimbursed up to 1 unit per month and shall provide a minimum of 2 hours of documented case management service and have completed a home visit each month in order to bill. Service time may consist of direct participant contact, guardian contact, phone calls to the participant or guardian, monitoring the participant in services, following up on concerns or questions regarding the participant, team meetings, plan of care development or updating, the monthly home visit, and service documentation review. A relative, parent, legally responsible person, or guardian may provide case management services to their ward/related participant if they meet all the provider requirements and complete the process to become a certified Medicaid Waiver case manager, including signing a Medicaid provider agreement.

A parent, legally responsible person, or guardian may not receive reimbursement for providing case management services. However, they can be reimbursed for case management services they provide to other Waiver participants, who have chosen them to provide these services. The parent/stepparent acting as an unpaid case manager shall not have a conflict of interest, which means that he/she cannot be a provider of any other service on the plan of care. If a relative provides services to a related waiver participant as a service provider, an employee of a service provider, or a self-directed employee, then the case manager on the participant's plan of care shall not have a conflict of interest to the relative provider or the participant, which means the case manager shall not be employed by or related to the relative provider or the participant (i.e. Sibling, child, grandparent, aunt, uncle, or other parent/step-parent, cousin, step family, or the participant's guardian).

The state monitors that there is no conflict of interest by reviewing the providers listed on the plan of care prior to service authorization and shall not approve the related case manager to provide other services on the plan of care. If hiring a relative through self-direction, the participant's case manager shall not have a conflict of interest with the relative or participant, which means the case manager shall not be a relative of the employee, participant, or the participant's legal representative. If a parent/stepparent is hired by a participant age 18 and over, whereas the Parent/stepparent is not operating as the Employer of Record, then the participant shall have an actively involved support broker to ensure that the she/he has engaged in recruitment activities and that there is a responsible person other than the paid family member, who, in addition to the participant, assumes employer responsibilities. In this arrangement, the participant cannot opt out of support brokerage. Case management services on the waiver can only be billed and reimbursed after the plan of care is approved by the Division. Prior to entrance to the waiver, targeted case management services are reimbursed through the Medicaid State Plan.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	individual certified to provide case management services
Agency	CARF-accredited agency certified to provide case management services
Agency	Agency certified to provide case management

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Case Management

Provider Category:
Individual

Provider Type:
individual certified to provide case management services

Provider Qualifications

License *(specify):*

Certificate *(specify):*
Any provider of this service is required to attain and maintain a certification for this service from the Wyoming Department of Health, Behavioral Health Division.

Other Standard *(specify):*

Case managers must have a minimum of one year experience in the field of intellectual disabilities/mental retardation and a Bachelor's degree, Master's degree or Doctoral degree; OR two years (48 credit hours) of college credit and two years of experience in the field of intellectual disability/mental retardation. Case Managers must complete a Criminal History Background check, maintain current CPR and First Aid Certification and have a current driver's license and automobile insurance if transporting participants. Case managers are required to complete and document participant specific training before serving a participant, and complete and document general trainings on recognizing abuse and neglect, incident reporting, complaint process requirements, documentation standards, provider recertification requirements, rights and rights restrictions, implementing objectives, self-directed services, and HIPAA & Confidentiality requirements. Case managers are required to facilitate team meetings, complete and submit the individual plan of care to the BHD for approval, and monitor the implementation of the individual plan of care, including health and safety, progress on objectives, satisfaction with services, and appropriateness and quality of services being provided, per Developmental Disabilities Division rules, Chapter 1. Case Managers must adhere to Chapter 1 of the Division rules, and Chapters 41 through 45 of the Wyoming Medicaid rules. All agencies that are certified to provide case management services are required to obtain an NPI number specific to case management services. In addition, all case managers employed with the organization are also required to have an NPI number specific to case management. These case managers are referred to as the treating provider for billing purposes and bill for case management services under their individual NPI numbers, which are linked to the organization's case management NPI number. The organization receives payment for case management services as the pay-to provider. For any other waiver services on the plan, the organization is required to bill using their original NPI number.

Verification of Provider Qualifications

Entity Responsible for Verification:

Behavioral Health Division

Frequency of Verification:

The Division initially certifies a new agency providing case management for one year and the agency is required to complete a recertification every year thereafter for the provision of case management services. The Division has the authority to monitor agencies throughout their recertification period through the complaint process, incident reporting process, or internal referral process if there is indication the case manager is not complying with the rules and regulations.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Case Management

Provider Category:

Agency

Provider Type:

CARF-accredited agency certified to provide case management services

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Any provider of this service is required to attain and maintain a certification for this service from the Wyoming Department of Health, Behavioral Health Division.

BHD requires providers to attain and maintain accreditation by the Commission on Accreditation of Rehabilitative Facilities (CARF) or other nationally recognized accreditation entity for human services as specified in Chapter 45 the Wyoming Medicaid rules.

Other Standard *(specify):*

Case managers must have a minimum of one year experience in the field of intellectual disabilities/mental retardation and a Bachelor's degree, Master's degree or Doctoral degree; OR two years (48 credit hours) of college credit and two years of experience in the field of intellectual disability/mental retardation. Case Managers must complete a Criminal History Background check, maintain current CPR and First Aid Certification and have a current driver's license and automobile insurance if transporting participants. Case managers are required to complete and document participant specific training before serving a participant, and complete and document general trainings on recognizing abuse and neglect, incident reporting, complaint process requirements, documentation standards, provider recertification requirements, rights and rights restrictions, implementing objectives, self-directed services, and HIPAA & Confidentiality requirements. Case managers are required to facilitate team meetings, complete and submit the individual plan of care to the BHD for approval, and monitor the implementation of the individual plan of care, including health and safety, progress on objectives, satisfaction with services, and appropriateness and quality of services being provided, per Developmental Disabilities Division rules, Chapter 1. Case Managers must adhere to Chapter 1 of the Division rules, and Chapters 41 through 45 of the Wyoming Medicaid rules. All agencies that are certified to provide case management services are required to obtain an NPI number specific to case management services. In addition, all case managers employed with the organization are also required to have an NPI number specific to case management. These case managers are referred to as the treating provider for billing purposes and bill for case management services under their individual NPI numbers, which are linked to the organization's case management NPI number. The organization receives payment for case management services as the pay-to provider. For any other waiver services on the plan, the organization is required to bill using their original NPI number.

Verification of Provider Qualifications

Entity Responsible for Verification:

Behavioral Health Division

Frequency of Verification:

The Division initially certifies a new agency providing case management for one year and the agency is required to complete a recertification every year thereafter for the provision of case management services. The Division has the authority to monitor agencies throughout their recertification period through the complaint process, incident reporting process, or internal referral process if there is indication the case manager is not complying with the rules and regulations.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Case Management

Provider Category:
Agency

Provider Type:
Agency certified to provide case management

Provider Qualifications

License *(specify):*

Certificate *(specify):*
Any provider of this service is required to attain and maintain a certification for this service from the Wyoming Department of Health, Behavioral Health Division.

Other Standard *(specify):*
Case managers must have a minimum of one year experience in the field of intellectual disabilities/mental retardation and a Bachelor's degree, Master's degree or Doctoral degree; OR two years (48 credit hours) of college credit and two years of experience in the field of intellectual disability/mental retardation. Case Managers must complete a Criminal History Background check, maintain current CPR and First Aid Certification and have a current driver's license and automobile insurance if transporting participants. Case managers are required to complete and document participant specific training before serving a participant, and complete and document general trainings on recognizing abuse and neglect, incident reporting, complaint process requirements, documentation standards, provider recertification requirements, rights and rights restrictions, implementing objectives, self-directed services, and HIPAA & Confidentiality requirements. Case managers are required to facilitate team meetings, complete and submit the individual plan of care to the BHD for approval, and monitor the implementation of the individual plan of care, including health and safety, progress on objectives, satisfaction with services, and appropriateness and quality of services being provided, per Developmental Disabilities Division rules, Chapter 1. Case Managers must adhere to Chapter 1 of the Division rules, and Chapters 41 through 45 of the Wyoming Medicaid rules. All agencies that are certified to provide case management services are required to obtain an NPI number specific to case management services. In addition, all case managers employed with the organization are also required to have an NPI number specific to case management. These case managers are referred to as the treating provider for billing purposes and bill for case management services under their individual NPI numbers, which are linked to the organization's case management NPI number. The organization receives payment for case management services as the pay-to provider. For any other waiver services on the plan, the organization is required to bill using their original NPI number.

Verification of Provider Qualifications

Entity Responsible for Verification:
Behavioral Health Division

Frequency of Verification:
The Division initially certifies a new agency providing case management for one year and the agency is required to complete a recertification every year thereafter for the provision of case management services. The Division has the authority to monitor agencies throughout their recertification period through the complaint process, incident reporting process, or internal referral process if there is indication the case manager is not complying with the rules and regulations.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:
Statutory Service

Service:
Day Habilitation

Alternate Service Title (if any):
Community Integration Services

HCBS Taxonomy:

Category 1:

04 Day Services

Sub-Category 1:

04070 community integration

Category 2:

04 Day Services

Sub-Category 2:

04020 day habilitation

Category 3:

Sub-Category 3:

Service

Category 4:

Sub-Category 4:

Definition *(Scope)*:

Community Integration Services services offer assistance with acquisition, retention, or improvement in self-help, socialization and adaptive skills that takes place in a non-residential setting, separate from the participant's private residence or other residential living arrangement.

Services should be furnished in any of a variety of settings in the community and are not limited to fixed-site facilities. Activities and environments are designed to foster the acquisition of skills, appropriate behavior, greater independence, community networking, and personal choice. Making connections with community members is a strong component of this service provision.

Community Integration services focus on enabling the participant to attain or maintain his or her maximum functional level and shall be coordinated with any physical, occupational, or speech therapies in the service plan. Services may serve to reinforce skills or lessons taught in other settings.
Services must be furnished consistent with the participant's person-centered plan and include options and opportunities for community integration, relationship-building, and an increased presence in one's community. Adult educational supports is an approved activity of this service.

This service must be delivered differently from Adult Day Services. This service requires a mixture of staff time helping a participant plan, access, participate, and interact with community members, businesses, volunteer activities, libraries, cultural, religious, or art centers, and build and maintain social connections at least half of the time each week during the provision of services.

Community Integration Services is a habilitative service that provides assistance and training with the acquisition and retention of skills. A % of services must address planning and participating in community integrated activities. Conversely, Adult Day Services is not habilitative and does not require community integrated activities. Adult Day Services are a supervision and support service to keep people who need the service in a safe, supervised setting that does not require the activity and objectives as habilitation services. Adult Day Services not implement as many opportunities for getting participants out into the community or participating in community events mainly due to comprised health issues and significant limitations of participants.

Individuals in Community Integration Services may not be paid for work activities performed during this service.

Personal care needed is a component part of the service as necessary to meet the needs of a participant, but may not comprise the entirety of the service nor can personal care services be billed in conjunction with this service during the same time.

Participants who receive this service may also receive Adult Day Services, Supported Employment and Prevocational services. A participant's service plan may include two or more types of non-residential habilitation services as long as service times do not overlap.

A Participant receives a tiered service approved in the plan of care based upon need, according to the following tiers descriptions:

Basic Level of Care
Levels 1 and 2 on the Level of Service Need grid will generally be in this tier. Service tier requires limited staff supports and personal attention to a participant daily due to a moderately high level of independence and functioning. Behavioral needs, if any, can be met with medication or informal direction by staff. The person may have periods of time with indirect staff supervision where staff are onsite and available through hearing distance of a request.

Intermediate Level of Care
Levels 3 and 4 on the Level of Service Need grid will generally be in this tier. Service tier requires full-time supervision with staff available on-site within line of sight due to significant functional limitations, medical and/or behavioral needs. Behavioral and medical supports are not generally intense and can be provided in a shared staffing setting. Regular personal attention is given throughout the day for training, personal care, reinforcement, community or social activities.

High Level of Care
Levels 5 and 6 on the Level of Service Need grid will generally be in this tier. Service tier requires full-time supervision with staff available on-site within absolute line of sight and frequent staff interaction and personal attention for significant functional limitations, medical and/or behavioral needs. Support and supervision needs are moderately intense, but can still generally be provided in a shared setting unless otherwise specified in the plan of care. Frequent personal attention given throughout the day for training, reinforcement, positive behavior support, personal care, community or social activities.

This service must be delivered with more community integration tracked than day habilitation, but until all plans of care transition to the new Community Integration service, day habilitation units and tiered rates will still be in effect for the first year of this service, then will be phased out and participant can choose this service instead.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

This is a habilitation service and objectives must be actively taught, with progress recorded to the case manager, participant and guardian monthly.

Approved units will be based on individual level of support need and must fit within the person's assigned budget.

Any relative providers may provide this service. Community Integration Habilitation services cannot be provided during the same time period as other waiver services, which is subject to audit by the Medicaid.

Transportation into the community to shop, attend recreational and civic events, or other community activities and resources, is a component of Community Integration Habilitation services and is included in the rate to providers.

The highest tiered rate for Community Integration service called "high level of care" will be available to participants, who want help building meaningful relationships and social connections in the community with a more individualized approach from the provider. A participant with any level of service need score may add the high level of care rate to the plan of care for individual services or services with up to one other waiver participant where the entire time is spent solely in the community and not in a facility.

Service Delivery Method *(check each that applies)*:

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)*:

- [ ] **Legally Responsible Person**
- [x] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agency certified by BHD to provide Community Integration Services
Agency	CARF Accredited agency certified to provide community integration services

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Community Integration Services

Provider Category:

Agency

Provider Type:

Agency certified by BHD to provide Community Integration Services

Provider Qualifications

License *(specify)*:

Certificate *(specify)*:

Any provider of this service is required to attain and maintain a certification for this service from the Wyoming Department of Health, Behavioral Health Division.

Other Standard *(specify)*:

An agency providing this service must meet the requirements in Wyoming Medicaid rules, Chapter 45, assuring any employee providing this service successfully passes a Criminal History Background check, attains and maintains current CPR and First Aid Certification for all direct care staff, has employees certified in Medication Assistance for participants who need help with medications, has employees certified in crisis intervention and restraint usage(such as CPI or Mandt) if provider is serving participants with those possible needs, and has documentation on file that any employee in the agency transporting a participant has a current driver's license and automobile insurance. Agency direct care staff must also complete and document participant specific training before serving a participant, and complete and document general trainings on recognizing abuse and neglect, incident reporting, complaint process requirements, documentation standards, participant rights and rights restrictions, implementing the participant's objectives, and HIPAA & confidentiality requirements.

The Agency must adhere to the standards and requirements specified in Wyoming Medicaid Rules Chapter 45 and also meet all other the applicable Medicaid rules and regulations specified in the BHD Provider manual and provider agreement.

The Agency providing this service shall have procedures in place to assure participants are involved in making informed employment-related decisions, participants are linked to services and community resources that enable them to achieve their employment objectives, participants are given information on local job opportunities, and participants' satisfaction with employment services is assessed on a regular basis.

For parent/stepparents provider agencies serving their child on the waiver, the agency shall become a certified Medicaid Waiver provider and an Limited Liability Company or a Corporation by the passage of House Enrolled Act 91 effective July 1, 2011.

Within one year of being certified in this service, 1 staff person working at least 50% of their time as a service supervisor must be certified in a nationally recognized supported employment curriculum and demonstrate that a portion of their time each month is spent training direct care staff on exploring employment interests, working on job readiness skills, or other employment related activities with participants.

Verification of Provider Qualifications

Entity Responsible for Verification:

Behavioral Health Division

Frequency of Verification:

The Division initially certifies a new agency providing this service for one year and the agency is required to complete a recertification every year thereafter for the provision of this service. The Division has the authority to monitor agencies throughout their recertification period through the complaint process, incident reporting process, or internal referral process if there is indication the provider is not complying with the rules and regulations.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Community Integration Services

Provider Category:

Agency

Provider Type:

CARF Accredited agency certified to provide community integration services

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Any provider of this service is required to attain and maintain a certification for this service from the Wyoming Department of Health, Behavioral Health Division. BHD requires a provider to attain and maintain accreditation by the Commission on Accreditation of Rehabilitative Facilities (CARF) or other nationally recognized accreditation entity for human services as specified in Chapter 45 the Wyoming Medicaid rules.

Other Standard *(specify):*

An agency providing this service must meet the requirements in Wyoming Medicaid rules, Chapter 45, assuring any employee providing this service successfully passes a Criminal History Background check, attains and maintains current CPR and First Aid Certification for all direct care staff, has employees certified in Medication Assistance for participants who need help with medications, has employees certified in crisis intervention and restraint usage(such as CPI or Mandt) if provider is serving participants with those possible needs, and has documentation on file that any employee in the agency transporting a participant has a current driver's license and automobile insurance. Agency direct care staff must also complete and document participant specific training before serving a participant, and complete and document general trainings on recognizing abuse and neglect, incident reporting, complaint process requirements, documentation standards, participant rights and rights restrictions, implementing the participant's objectives, and HIPAA & confidentiality requirements.

The Agency must adhere to the standards and requirements specified in Wyoming Medicaid Rules Chapter 45 and also meet all other the applicable Medicaid rules and regulations specified in the BHD Provider manual and provider agreement.

The Agency providing this service shall have procedures in place to assure participants are involved in making informed employment-related decisions, participants are linked to services and community resources that enable them to achieve their employment objectives, participants are given information on local job opportunities, and participants' satisfaction with employment services is assessed on a regular basis.

For parent/stepparents provider agencies serving their child on the waiver, the agency shall become a certified Medicaid Waiver provider and an Limited Liability Company or a Corporation by the passage of House Enrolled Act 91 effective July 1, 2011.

Within one year of being certified in this service, 1 staff person working at least 50% of their time as a service supervisor must be certified in a nationally recognized supported employment curriculum and demonstrate that a portion of their time each month is spent training direct care staff on exploring employment interests, working on job readiness skills, or other employment related activities with participants.

Verification of Provider Qualifications

Entity Responsible for Verification:

Behavioral Health Division

Frequency of Verification:

The Division initially certifies a new agency providing this service for one year and the agency is required to complete a recertification every year thereafter for the provision of this service. The Division has the authority to monitor agencies throughout their recertification period through the complaint process, incident reporting process, or internal referral process if there is indication the provider is not complying with the rules and regulations.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Homemaker

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:	Sub-Category 1:
08 Home-Based Services	08060 chore
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Provider Category	Provider Type Title

Homemaker services consisting of general household activities such as meal preparation and routine household care, which are provided by a trained homemaker when the individual regularly responsible for these activities is unable to manage the home and care for himself/herself or others in the home or when the person who usually does these things is temporarily unavailable or unable to perform the tasks.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Cap per year is a maximum of 3 hours per week per household or 624 units. Service is not available to participants who receive residential habilitation services on the waiver. Relative providers (excluding parents/stepparents) may provide this service.

Service Delivery Method *(check each that applies)*:

- [x] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)*:

- [ ] **Legally Responsible Person**
- [x] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	CARF-accredited agency certified to provide homemaker services
Agency	Agency certified by BHD to provide Homemaker services
Individual	Individual Hired by the participant

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Homemaker

Provider Category:

Agency

Provider Type:

CARF-accredited agency certified to provide homemaker services

Provider Qualifications

License *(specify):*

Certificate *(specify):*

CARF-accredited agencies providing homemaker services that are also providing residential habilitation services or day habilitation services to three or more participants are required to obtain and maintain CARF accreditation per Wyoming Medicaid rules, Chapter 45, Section 21.

Other Standard *(specify):*

An agency providing this service must meet the requirements in Wyoming Medicaid rules, Chapter 45, including assuring any employee providing this service successfully passes a Criminal History Background check, attains and maintains current CPR and First Aid Certification for all direct care staff, and has documentation on file that any employee in the agency transporting a participant has a current driver's license and automobile insurance. Agency staff must also complete and document general trainings on recognizing abuse and neglect, incident reporting, complaint process requirements, documentation standards, rights and rights restrictions, implementing the participant's objectives, and HIPAA & confidentiality requirements.

The Agency must adhere to the standards and requirements specified in Wyoming Medicaid Rules Chapter 45 and also meet all other the applicable Medicaid rules and regulations specified in the BHD Provider manual and provider agreement.

Verification of Provider Qualifications

Entity Responsible for Verification:

Behavioral Health Division

Frequency of Verification:

The Division initially certifies a CARF agency providing this service for one year and the agency is required to complete a recertification in all services provided every year thereafter. The Division has the authority to monitor agencies throughout their recertification period through the complaint process, incident reporting process, or internal referral process if there is indication the provider is not complying with the rules and regulations.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Homemaker

Provider Category:
Agency

Provider Type:
Agency certified by BHD to provide Homemaker services

Provider Qualifications

License *(specify):*

Certificate *(specify):*
Any provider of this service is required to attain and maintain a certification for this service from the Wyoming Department of Health, Behavioral Health Division.

Other Standard *(specify):*
An agency providing this service must meet the requirements in Wyoming Medicaid rules, Chapter 45, including assuring any employee providing this service successfully pass a Criminal History Background check, and complete and document general trainings on recognizing abuse and neglect, incident reporting, complaint process requirements, documentation standards, and HIPAA & confidentiality requirements.

The Agency must adhere to the standards and requirements specified in Wyoming Medicaid Rules Chapter 45 and also meet all other the applicable Medicaid rules and regulations specified in the BHD Provider manual and provider agreement.

Verification of Provider Qualifications

Entity Responsible for Verification:
Behavioral Health Division

Frequency of Verification:
BHD initially certifies an agency providing this service for one year and the agency is required to complete a recertification at the end of the first year. After the initial year certification, BHD may certify an agency in this service for up to two years. An agency, who receives a recommendation that identifies non-compliance with any rule and regulation pertaining to health, safety, rights or the standards for habilitation service provision may only receive up to a one-year recertification pending corrective action on the area of non-compliance. An agency, who does not receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation service standards may receive a two-year recertification. BHD has the authority to monitor agencies throughout their recertification period through the complaint process, incident reporting process, or internal referral process, if there is indication the agency is not complying with the rules and regulations.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Homemaker

Provider Category:
Individual

Provider Type:
Individual Hired by the participant

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

The Fiscal/Employer Agent Financial Management Service verifies with documentation in a file that the individual being hired to provide this service:
- Is at least 18 years of age
- Has completed a successful criminal background check
- Has the ability to communicate effectively with the individual/family
- Has the ability to complete record keeping as required by the employer

The participant and/or legal representative, with assistance as needed from the Support Broker or case manager, verifies that, prior to working alone with the participant, the individual being hired demonstrates competence in knowledge of the following BHD policies and procedures:
- Recognizing abuse/neglect;
- Incident reporting;
- Participant rights and confidentiality;
- Emergency drills/situations; and
- Documentation standards;

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Employer Agent- Financial Management Service

Frequency of Verification:

Employees hired for this service through the Financial Management Service are required to attain, maintain, and show evidence of a successful Criminal History background prior to being employed and providing waiver services.

Once an employee shows that all documentation is submitted, the Fiscal Employer Agent – FMS database is updated and the FMS allows the employee to start work.

Fiscal Employer Agent – FMS also does quarterly reviews on a random sample of files to ensure that all required documents are submitted and logged correctly in the database and file.

The Agent provides a weekly status report to support brokers regarding provider certifications, paperwork, status of trainings, and whether or not the provider has met all requirements to work for a participant. The Agent also provides a monthly report to support brokers, which includes a status of upcoming training expirations of providers. The fiscal agent suspends all payments of a provider who lapses on their certification and notifies the provider and EOR.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Personal Care

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:	Sub-Category 1:
08 Home-Based Services	08030 personal care
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**

Service Definition *(Scope):*

Category 4: **Sub-Category 4:**

A range of assistance to enable waiver participants to accomplish tasks that they would normally do for themselves if they did not have a disability. Assistance may take the form of hands-on assistance (actually performing a task for the person) or cuing to prompt the participant to perform a task. Personal care services may be provided on an episodic or on a continuing basis. Health-related services that may be provided includes care relating to medical or health protocols, medication assistance or administration, and range of motion exercises. Health related services may be provided after staff are trained by the appropriate trainer or medical professional and documentation of training is included in the staff person's personnel file.

Such assistance may include assistance in performing activities of daily living (ADLs-bathing dressing, toileting, transferring, maintaining continence) and instrumental activities of daily living on the person's property (IADLs-more complex life activities, e.g. personal hygiene, light housework, laundry, meal preparation exclusive of the cost of the meal, using the telephone, medication and money management). Transportation costs are not included as part of this service.

The participant must be physically present. Personal care shall be provided in the participant's home or on their property. If the individual providing this service is not employed and supervised by an agency, then the participant is responsible for supervising the individual and may coordinate monitoring of the service with his/her case manager.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

This service is available to all ages and is a 1:1 service. Units shall be approved based upon need, fit within the person's assigned budget, with a maximum annual cap of 6000 units for persons in a non-residential service setting.

For participants in a residential service, personal care units may be approved up to 7280 units a year only when the participant needs ongoing supervision but cannot attend a day service due to a medical or health condition that prohibits or limits attendance at a congregate day program upon verification of need and approval of the Division.

Personal care services are included in Companion, Supported Living, Adult Day Services, Community Integration Habilitation, Prevocational, Supported Employment, and Residential Habilitation services; therefore, Personal Care cannot be provided in conjunction with those services and if provided on the same day, service times must not overlap.

Personal care cannot be provided during the same time period as other waiver services, which is subject to audit by the Program Integrity Unit within the Single State Medicaid Agency. The amount of personal care services prior authorized by the Division for the legally responsible individual will be based upon individual extraordinary care needs as specified in the individualized plan of care and other assessments.

Personal care is not covered as a stand-alone service through the state plan. It can be provided through home health only. A home health provider typically provides services from 8 am to 5 pm. Being a rural state, many Wyoming communities do not have home health providers to serve their community. Those that do, often do not have enough employees to meet the extensive needs of some waiver participants. Waiver participants who need personal care services must utilize providers that can provide the type, amount and flexible hours of services deemed most appropriate for the participant. The waiver service allows the team to find and utilize providers who can best meet the participant's needs.

Any relative providers may provide this service. For relative providers residing in the same household as the waiver participant, personal care provided by the relative provider in the home shall be for extraordinary care only, as defined by the Division, and cannot exceed four (4) hours per day per participant. Legally Responsible Individuals (parent/stepparent/guardian) of minor children may be a provider of personal care for extraordinary care needs with the same limit of 4 hours a day per participant. It is expected that for those participants living with their families, that the family members will contribute natural support and supervision, similar to how families function. Additional units needed beyond 4 hours a day require additional documentation and shall only be approved by the Division's Extraordinary Care Committee.

For personal care provided to participants under age 18 by a legally responsible individual, payment shall only be authorized for extraordinary care services provided by the legally responsible individual provider as documented in the plan of care and align with the assessed needs of the participant which show the need for extraordinary care.

Extraordinary care cases shall meet the following criteria:
1. The participant's Adaptive Behavior Quotient is 0.35 or lower on the Inventory for Client and Agency Planning (ICAP) assessment; and either 2 or 3
2. The participant needs assistance with Activities of Daily living (ADLs) or Instrumental Activities of Daily Living (IADLs) exceeding the range of expected activities that a legally responsible individual would ordinarily perform in the household on behalf of a person without a disability or chronic illness of the same age, and which are necessary to assure the health and welfare of the participant and avoid institutionalization. (Example: a 12 year old needing assistance with dressing and bathing, whereas the average 12 year old does not.); or
3. The participant requires care from a person with specialized medical skills relating to the participant's diagnosis or medical condition as determined appropriate by the participant's medical professional and the Behavioral Health Division.

If a legally responsible individual is providing personal care to his/her ward, the plan of care shall be developed and monitored by a case manager without a conflict of interest to the legally responsible individual provider or to the participant, which means the case manager shall not be employed by or related to the provider or the participant (i.e. sibling, child, grandparent, aunt, uncle, or other parent/step-parent, cousin, step family, or the participant's guardian), to ensure the provision of services is in the best interest of the participant.

The plan shall document that services do not duplicate similar services, natural supports, or services otherwise available to the participant.

Service Delivery Method *(check each that applies)*:

- [x] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [ ] **Legally Responsible Person**
- [x] **Relative**

Provider Category	Provider Type Title
Legal Guardian	

Provider Specifications:

Provider Category	Provider Type Title
Agency	CARF-accredited agency also certified by BHD for Personal Care
Individual	Individual Hired by the participant
Agency	Agency certified by BHD to provide Personal Care

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Personal Care

Provider Category:
Agency

Provider Type:
CARF-accredited agency also certified by BHD for Personal Care

Provider Qualifications

License *(specify):*

Certificate *(specify):*
Any provider of this service is required to attain and maintain a certification for this service from the Wyoming Department of Health, Behavioral Health Division. BHD requires a provider to attain and maintain accreditation by the Commission on Accreditation of Rehabilitative Facilities (CARF) or other nationally recognized accreditation entity for human services as specified in Chapter 45 the Wyoming Medicaid rules.

Other Standard *(specify):*
An agency providing this service must meet the requirements in Wyoming Medicaid rules, Chapter 45, including assuring any employee providing this service successfully passes a Criminal History Background check, attains and maintains current CPR and First Aid Certification for all direct care staff, has employees certified in Medication Assistance for participants who need help with medications, has employees certified in crisis intervention and restraint usage(such as CPI or Mandt) if provider is serving participants with those possible needs, and has documentation on file that any employee in the agency transporting a participant has a current driver's license and automobile insurance. Agency direct care staff must also complete and document participant specific training before serving a participant, and complete and document general trainings on recognizing abuse and neglect, incident reporting, complaint process requirements, documentation standards, participant rights and rights restrictions, implementing the participant's objectives, and HIPAA & confidentiality requirements.

The Agency must adhere to the standards and requirements specified in Wyoming Medicaid Rules Chapter 45 and also meet all other the applicable Medicaid rules and regulations specified in the BHD Provider manual and provider agreement.

For parent/stepparents provider agencies serving their child on the waiver, the agency shall become a certified Medicaid Waiver provider and an Limited Liability Company or a Corporation by the passage of House Enrolled Act 91 effective July 1, 2011.

Verification of Provider Qualifications

Entity Responsible for Verification:
Behavioral Health Division

Frequency of Verification:
The Division initially certifies a CARF agency providing this service for one year and the agency is required to complete a recertification in all services provided every year thereafter. The Division has the authority to monitor agencies throughout their recertification period through the complaint process, incident reporting process, or internal referral process if there is indication the provider is not complying with the rules and regulations.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Personal Care

Provider Category:
Individual

Provider Type:

Individual Hired by the participant

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

The Fiscal/Employer Agent Financial Management Service verifies with documentation in a file that the individual being hired to provide this service:
Is at least 18 years of age
- Has completed a successful criminal background check
- Has the ability to communicate effectively with the individual/family
- Has the ability to complete record keeping as required by the employer
- Has current CPR and First Aid Certification
- Has current Medication Assistance Training certification, if applicable
- Has Crisis Intervention and Restraint usage certification, such as CPI or Mandt, if applicable for participant's needs
- Has a current driver's license and automobile insurance if transporting the participant

The participant and/or legal representative, with assistance as needed from the Support Broker or case manager, verifies that, prior to working alone with the participant, the individual being hired demonstrates competence in knowledge of the following BHD policies and procedures:
- Recognizing abuse/neglect;
- Incident reporting;
- Participant rights and confidentiality;
- Emergency drills/situations;
- Documentation standards; and
- Demonstrates competence/knowledge in participants needs outlined in the individual plan of care

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Employer Agent- Financial Management Service

Frequency of Verification:

Employees hired through the Financial Management Service are required to attain, maintain, and show evidence of a successful Criminal History background, current CPR and First Aid certification, medication assistance training (if applicable) current driver's license and vehicle insurance (if transporting participants), and current certification in crisis intervention and restraint usage (if applicable for the participant's needs) prior to being employed and providing waiver services.

The Fiscal Employer Agent - FMS inputs all employee information into a database, which shows each item that an employee has completed in order to qualify to provide services to a participant. Any documentation that has an expiration date is entered into their database as to the date of when it expires and flags them to notify the employee and employer of record and support broker when an item is expiring.

Once an employee shows that all documentation is submitted, the Fiscal Employer Agent – FMS database is updated and the FMS allows the employee to start work.

Fiscal Employer Agent – FMS also does quarterly reviews on a random sample of files to ensure that all required documents are submitted and logged correctly in the database and file.

The Agent provides a weekly status report to support brokers regarding provider certifications, paperwork, status of trainings, and whether or not the provider has met all requirements to work for a participant. The Agent also provides a monthly report to support brokers, which includes a status of upcoming training expirations of providers. The fiscal agent suspends all payments of a provider who lapses on their certification and notifies the provider and EOR.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Personal Care

Provider Category:

Agency

Provider Type:

Agency certified by BHD to provide Personal Care

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Any provider of this service is required to attain and maintain a certification for this service from the Wyoming Department of Health, Behavioral Health Division.

Other Standard *(specify):*

An agency providing this service must meet the requirements in Wyoming Medicaid rules, Chapter 45, including assuring any employee providing this service successfully passes a Criminal History Background check, attains and maintains current CPR and First Aid Certification for all direct care staff, has employees certified in Medication Assistance for participants who need help with medications, has employees certified in crisis intervention and restraint usage(such as CPI or Mandt) if provider is serving participants with those possible needs, and has documentation on file that any employee in the agency transporting a participant has a current driver's license and automobile insurance. Agency direct care staff must also complete and document participant specific training before serving a participant, and complete and document general trainings on recognizing abuse and neglect, incident reporting, complaint process requirements, documentation standards, participant rights and rights restrictions, implementing the participant's objectives, and HIPAA & confidentiality requirements.

The Agency must adhere to the standards and requirements specified in Wyoming Medicaid Rules Chapter 45 and also meet all other the applicable Medicaid rules and regulations specified in the BHD Provider manual and provider agreement.

For parent/stepparents provider agencies serving their child on the waiver, the agency shall become a certified Medicaid Waiver provider and an Limited Liability Company or a Corporation by the passage of House Enrolled Act 91 effective July 1, 2011.

Verification of Provider Qualifications

Entity Responsible for Verification:

Behavioral Health Division

Frequency of Verification:

BHD initially certifies an agency providing this service for one year and the agency is required to complete a recertification at the end of the first year. After the initial year certification, BHD may certify an agency in this service for up to two years. An agency, who receives a recommendation that identifies non-compliance with any rule and regulation pertaining to health, safety, rights or the standards for habilitation service provision may only receive up to a one-year recertification pending corrective action on the area of non-compliance. An agency, who does not receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation service standards may receive a two-year recertification. BHD has the authority to monitor agencies throughout their recertification period through the complaint process, incident reporting process, or internal referral process, if there is indication the agency is not complying with the rules and regulations.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Prevocational Services

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:

04 Day Services

Sub-Category 1:

04010 prevocational services

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Provider Category	Provider Type Title

Service

Category 4:

Sub-Category 4:

Definition *(Scope):*

Prevocational services are services designed to create a path to integrated community based employment for which an individual is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. Prevocational services should enable each individual to attain the highest level of work in the most integrated setting and with the job matched to the individual's interests, strengths, priorities, abilities, and capabilities, while following applicable federal wage guidelines. Services provide learning and work experiences, including volunteer work, where the individual can develop general, non-job-task-specific strengths and skills that contribute to employability in paid employment in integrated community settings.

- Services include teaching and monitoring concepts, such as compliance, attendance, task completion, problem solving, interpersonal relationships, and safety during each day of service provided. Services are not job-task oriented, but aimed at generalized results.
- Service activities must be reflected in the participant's plan of care and are directed to habilitative, rather than employment objectives. Employment objectives are linked to other services on the waiver.
- Services may be furnished in a variety of locations in the community and are not limited to provider facilities.
- Prevocational services may be provided at a volunteer worksite or mentorship locations for the purpose of teaching job preparedness for a specific type of work.
- Participation in prevocational services is not a required pre-requisite for individual or small group supported employment services furnished under the waiver.
- Prevocational services are time-limited and should not to exceed 12 consecutive months. In some cases, an additional 12 months may be approved by the Division in subsequent years with submission of an approved employment plan (through vocational rehabilitation, school district, or the waiver) and upon review of active progress made the prior year on finding employment opportunities, increasing work skills, time on tasks, or other job preparedness objectives.
- A monthly objective must be included in the provision of services relating to either volunteering, mentoring, increasing involvement with community members, improving communication with community members, and accessing other resources to further employment development, such as curriculum based trainings, online information modules on careers, or resources from the community or other agencies that will potentially prepare the participant to a job outside of the provider facility.
- If no progress on prevocational objectives and the employment plan occur, the Division may not approve the service in subsequent years and other waiver services may be accessed to the meet supervision and support needs of the participant.
- Services are reimbursed based upon the participant's level of service need.
- Transportation is included in the reimbursement rate.

A Participant receives a tiered service approved in the plan of care based upon need, according to the following tiers descriptions:

Basic Level of Care
Levels 1 and 2 on the Level of Service Need Grid will generally be in this tier. Service tier requires limited staff supports and personal attention to a participant daily due to a moderately high level of independence and functioning. Behavioral needs, if any, can be met with medication or informal direction by staff. The person may have periods of time with indirect staff supervision where staff are onsite and available through hearing distance of a request.

Intermediate Level of Care
Levels 3 and 4 on the Level of Service Need Grid will generally be in this tier. Service tier requires full-time supervision with staff available on-site within line of sight due to significant functional limitations, medical and/or behavioral needs. Behavioral and medical supports are not generally intense and can be provided in a shared staffing setting. Regular personal attention is given throughout the day for training, personal care, reinforcement, community or social activities.

High Level of Care
Levels 5 and 6 on the Level of Service Need Grid will generally be in this tier. Service tier requires full-time supervision with staff available on-site within absolute line of sight and frequent staff interaction and personal attention for significant functional limitations, medical and/or behavioral needs. Support and supervision needs are moderately intense, but can still generally be provided in a shared setting unless otherwise specified in the plan of care. Frequent personal attention given throughout the day for training, reinforcement, positive behavior support, personal care, community or social activities.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Prevocational service is a habilitation service and objectives must be actively taught, with progress recorded to the case manager, participant and guardian monthly.

Individuals participating in prevocational services may be compensated in accordance with applicable Federal laws and regulations; however, waiver funding is not available for the provision of vocational services delivered in facility-based or sheltered work settings, where individuals are supervised for the primary purpose of producing goods or performing services.

Documentation must be maintained in the provider and case manager's file for each participant receiving this service that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.).

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agency certified by BHD to provide Prevocational Services
Agency	CARF-accredited agency also certified by BHD for Prevocational Services

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Prevocational Services

Provider Category:

Agency

Provider Type:

Agency certified by BHD to provide Prevocational Services

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Any provider of this service is required to attain and maintain a certification for this service from the Wyoming Department of Health, Behavioral Health Division.

Other Standard *(specify):*

An agency providing this service must meet the requirements in Wyoming Medicaid rules, Chapter 45, including assuring any employee providing this service successfully passes a Criminal History Background check, attains and maintains current CPR and First Aid Certification for all direct care staff, has employees certified in Medication Assistance for participants who need help with medications, has employees certified in crisis intervention and restraint usage(such as CPI or Mandt) if provider is serving participants with those possible needs, and has documentation on file that any employee in the agency transporting a participant has a current driver's license and automobile insurance. Agency direct care staff must also complete and document participant specific training before serving a participant, and complete and document general trainings on recognizing abuse and neglect, incident reporting, complaint process requirements, documentation standards, participant rights and rights restrictions, implementing the participant's objectives, and HIPAA & confidentiality requirements.

The Agency must adhere to the standards and requirements specified in Wyoming Medicaid Rules Chapter 45 and also meet all other the applicable Medicaid rules and regulations specified in the BHD Provider manual and provider agreement.

The Agency providing this service shall have procedures in place to assure participants are involved in making informed employment-related decisions, participants are linked to services and community resources that enable them to achieve their employment objectives, participants are given information on local job opportunities, and participants' satisfaction with employment services is assessed on a regular basis.

For parent/stepparents provider agencies serving their child on the waiver, the agency shall become a certified Medicaid Waiver provider and an Limited Liability Company or a Corporation by the passage of House Enrolled Act 91 effective July 1, 2011.

Within one year of being certified in this service, 1 staff person working at least 50% of their time as a service supervisor must be certified in a nationally recognized supported employment curriculum and demonstrate that a portion of their time each month is spent training direct care staff on exploring employment interests, working on job readiness skills, or other employment related activities with participants.

Verification of Provider Qualifications

Entity Responsible for Verification:

Behavioral Health Division

Frequency of Verification:

BHD initially certifies an agency providing this service for one year and the agency is required to complete a recertification at the end of the first year. After the initial year certification, BHD may certify an agency in this service for up to two years. An agency, who receives a recommendation that identifies non-compliance with any rule and regulation pertaining to health, safety, rights or the standards for habilitation service provision may only receive up to a one-year recertification pending corrective action on the area of non-compliance. An agency, who does not receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation service standards may receive a two-year recertification. BHD has the authority to monitor agencies throughout their recertification period through the complaint process, incident reporting process, or internal referral process, if there is indication the agency is not complying with the rules and regulations.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Prevocational Services

Provider Category:

Agency

Provider Type:

CARF-accredited agency also certified by BHD for Prevocational Services

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Any provider of this service is required to attain and maintain a certification for this service from the Wyoming Department of Health, Behavioral Health Division.

BHD requires a provider to attain and maintain accreditation by the Commission on Accreditation of Rehabilitative Facilities (CARF) or other nationally recognized accreditation entity for human services as specified in Chapter 45 the Wyoming Medicaid rules.

Other Standard *(specify):*

An agency providing this service must meet the requirements in Wyoming Medicaid rules, Chapter 45, including assuring any employee providing this service successfully passes a Criminal History Background check, attains and maintains current CPR and First Aid Certification for all direct care staff, has employees certified in Medication Assistance for participants who need help with medications, has employees certified in crisis intervention and restraint usage(such as CPI or Mandt) if provider is serving participants with those possible needs, and has documentation on file that any employee in the agency transporting a participant has a current driver's license and automobile insurance. Agency direct care staff must also complete and document participant specific training before serving a participant, and complete and document general trainings on recognizing abuse and neglect, incident reporting, complaint process requirements, documentation standards, participant rights and rights restrictions, implementing the participant's objectives, and HIPAA & confidentiality requirements.

The Agency must adhere to the standards and requirements specified in Wyoming Medicaid Rules Chapter 45 and also meet all other the applicable Medicaid rules and regulations specified in the BHD Provider manual and provider agreement.

The Agency providing this service shall have procedures in place to assure participants are involved in making informed employment-related decisions, participants are linked to services and community resources that enable them to achieve their employment objectives, participants are given information on local job opportunities, and participants' satisfaction with employment services is assessed on a regular basis.

For parent/stepparents provider agencies serving their child on the waiver, the agency shall become a certified Medicaid Waiver provider and an Limited Liability Company or a Corporation by the passage of House Enrolled Act 91 effective July 1, 2011.

Within one year of being certified in this service, 1 staff person working at least 50% of their time as a service supervisor must be certified in a nationally recognized supported employment curriculum and demonstrate that a portion of their time each month is spent training direct care staff on exploring employment interests, working on job readiness skills, or other employment related activities with participants.

Verification of Provider Qualifications

Entity Responsible for Verification:

Behavioral Health Division

Frequency of Verification:

The Division initially certifies a CARF agency providing this service for one year and the agency is required to complete a recertification in all services provided every year thereafter. The Division has the authority to monitor agencies throughout their recertification period through the complaint process, incident reporting process, or internal referral process if there is indication the provider is not complying with the rules and regulations.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Residential Habilitation

Alternate Service Title (if any):

HCBS Taxonomy:

Service

Category 1: 02 Round-the-Clock Services

Sub-Category 1: 02011 group living, residential habilitation

Category 2: 02 Round-the-Clock Services

Sub-Category 2: 02021 shared living, residential habilitation

Category 3: 02 Round-the-Clock Services

Sub-Category 3: 02031 in-home residential habilitation

Category 4:

Sub-Category 4:

Definition *(Scope):*

Residential Habilitation services are individually-tailored supports for a waiver participant that assists with the acquisition, retention, or improvement in skills related to living in the community. These supports include adaptive skill development, assistance with activities of daily living, community inclusion, transportation, adult educational supports, social and leisure skill development, that assist the participant to reside in the most integrated setting appropriate to his/her needs. Residential Habilitation includes personal care, protective oversight and supervision.

- Residential Habilitation services are reimbursed using a daily unit based upon the level of service need of the participant, where the participant needs some level of ongoing 24 hour support by a provider on site.
- Services can be furnished in a group home, shared living arrangement, host home, or in the participant's home.
- Residential Habilitation may be furnished in a home owned or leased by a provider or the participant.
- For Residential Habilitation delivered through self-direction as Shared Living- This service may be self-directed for an individual in a shared living setting, where the participant or participants own or lease the residence from an entity that is not a certified waiver provider. The employee hired through self-direction may serve up to 3 people in shared living, but can serve no other people in a residential habilitation service.
- Provider owned or leased facilities where Residential Habilitation services are furnished must be compliant with the Americans with Disabilities Act.
- Transportation between the participant's place of residence, other service sites, or places in the community is included in the rate.
- Residential habilitation services must be furnished in living arrangements subject to §1616(e) of the Social Security Act (the Keys Amendment), and the standards for such services must meet Chapter 45 of the Wyoming Medicaid Rules for facility standards, including assuring that the living arrangement is homelike rather than institutional in character.

Tiered Levels
A Participant receives a tiered service approved in the plan of care based upon need, according to the following tiers descriptions. Tier levels for this service align with the assessed Level of Service Need for the participant and the expectations of the service as specified in the definition. All supervision and supports delivered must align with the participant's plan of care.

Level 1 –Due to a high level of independence and functioning and no significant behavioral or medical issues, this tier requires staff available on-site and meeting periodically with the participant during awake hours on each day billed to provide general supervision, support, monitoring, training, and on-call 24 hour support.

Level 2- Due to a moderately high level of independence and functioning and few behavioral or medical issues, if any, that require minimal staff support, monitoring, or personal care, this tier requires staff available on-site within close proximity to the person's residence at all times, meeting periodically with the participant during awake hours on each day billed to provide general supervision, support, monitoring, training and on-call 24 hour support.

Level 3- Due to moderate functional limitations in activities of daily living and possible behavioral support needs, this tier requires staff available on-site within hearing distance in the same residence as the participant and meeting periodically with the participant on each day billed for general supervision, support, personal care, positive behavior support, monitoring, training and staff support through the night in the residence or in a near-by office.

Level 4- Due to significant functional limitations, medical and/or behavioral support needs, this tier requires full-time staff to be on-site in the person's residence when the person is in this service, with regular personal attention given throughout the day for training, personal care, reinforcement, positive behavior support, community or social activities. Behavioral and medical supports are not generally intense and can be provided in a shared staffing setting. There must be staff support in the residence through the night.

Level 5-- Due to significant and somewhat intensive functional limitations, medical and/or behavioral support needs, this tier requires 1 or more full-time staff support to be on-site and in line of sight during most awake hours when the person is in this service, with frequent personal attention given throughout the day for training, personal care, reinforcement, community or social activities. Behavioral and medical supports or personal care may be somewhat intense but service may be provided in a smaller shared staffing setting. Overnight expectations are stipulated in the plan of care.

Level 6-Due to the high medical, behavioral and/or personal care needs, this tier requires frequent personal support and supervision with full-time staff on-site and within line of sight during most awake hours. The expectation is that the participant shall receive the attention of at least one to two caregiver(s) as specified in the plan of care. Staffing ratios during the day and night must be kept as approved by BHD in the plan of care.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

The provision of Residential Habilitation services is provided to personal care needs, so plans of care are not approved that include both residential services and personal care services.

Since residential habilitation is paying for support to an individual who needs support 24 hours a day, the provider must be in the residence of the participant providing service during both awake and sleeping time for a minimum of 8 hours in a 24 hour period (from 12:00am-11:59pm) for the provider to be reimbursed.

Family visits and trips are encouraged. The provider will be allowed to be reimbursed on the day the participant returns home from a trip.

Payment is not made, directly or indirectly, to members of the participant's immediate family, except as provided in Appendix C-2 of the waiver application. Payment is not be made for the cost of room and board, including the cost of building maintenance, upkeep and improvement. The method by which the costs of room and board are excluded from payment for Residential Habilitation is specified in Appendix I-5 of the waiver application.

Relative providers may provide all components of this service as defined with the following limitations:
- A relative (excluding parents/stepparents/legal authorized representatives) may provide this service to the participant while residing in the same residence as the participant.
- A relative who is a parent/stepparent, and a certified provider and LLC or a corporation or an employee of a certified provider, may provide this service as defined but shall not live or reside in the same residence as the participant.

Targeting Criteria to receive this service
Waiver participants not receiving 24-hour residential services, who are at significant risk due to extraordinary needs that cannot be met in their current living arrangement, may request 24-hour Residential Habilitation services if the participant meets one of the following targeting criteria:
- A substantial threat to a person's life or health caused by homelessness or abuse/neglect that is either substantiated by Department of Family Services or corroborated by the Behavioral Health Division or Protection & Advocacy Systems, Inc.
- Situations where the person's condition poses a substantial threat to a person's life or health, and is documented in writing by a physician.
- Situations where a person has caused serious physical harm to him or herself or someone else in the home, or the person's condition presents a substantial risk of physical threat to him or herself or others in the home.
- Situations where there are significant and frequently occurring behavior challenges resulting in danger to the person's health and safety, or the health and safety of others in the home.
- Situations where the person's critical medical condition requires ongoing 24-hour support and supervision to maintain the person's health and safety.
- Loss of primary caregiver due to caregiver's death, incapacitation, critical medical condition, or inability to provide continuous care.

Service Delivery Method *(check each that applies)*:

- [x] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)*:

- [ ] **Legally Responsible Person**
- [x] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	CARF Accredited agency certified to provide residential habilitation services
Agency	Agency certified by BHD to provide Residential Habilitation
Individual	Individual Hired by the participant for shared living (res hab)

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Residential Habilitation

Provider Category:
Agency

Provider Type:
CARF Accredited agency certified to provide residential habilitation services

Provider Qualifications

License *(specify):*

Certificate *(specify):*
Any provider of this service is required to attain and maintain a certification for this service from the Wyoming Department of Health, Behavioral Health Division. BHD requires a provider to attain and maintain accreditation by the Commission on Accreditation of Rehabilitative Facilities (CARF) or other nationally recognized accreditation entity for human services as specified in Chapter 45 the Wyoming Medicaid rules.

Other Standard *(specify):*

An agency providing this service must meet the requirements in Wyoming Medicaid rules, Chapter 45, including assuring any employee providing this service successfully passes a Criminal History Background check, attains and maintains current CPR and First Aid Certification for all direct care staff, has employees certified in Medication Assistance for participants who need help with medications, has employees certified in crisis intervention and restraint usage(such as CPI or Mandt) if provider is serving participants with those possible needs, and has documentation on file that any employee in the agency transporting a participant has a current driver's license and automobile insurance. Agency direct care staff must also complete and document participant specific training before serving a participant, and complete and document general trainings on recognizing abuse and neglect, incident reporting, complaint process requirements, documentation standards, rights and rights restrictions, implementing the participant's objectives, and HIPAA & confidentiality requirements.

The Agency must adhere to the standards and requirements specified in Wyoming Medicaid Rules Chapter 45 and also meet all other the applicable Medicaid rules and regulations specified in the BHD Provider manual and provider agreement.

For parent/stepparents provider agencies serving their child on the waiver, the agency shall become a certified Medicaid Waiver provider and an Limited Liability Company or a Corporation by the passage of House Enrolled Act 91 effective July 1, 2011.

Verification of Provider Qualifications

Entity Responsible for Verification:

Behavioral Health Division

Frequency of Verification:

The Division initially certifies a CARF agency providing this service for one year and the agency is required to complete a recertification in all services provided every year thereafter. The Division has the authority to monitor agencies throughout their recertification period through the complaint process, incident reporting process, or internal referral process if there is indication the provider is not complying with the rules and regulations.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Residential Habilitation

Provider Category:

Agency

Provider Type:

Agency certified by BHD to provide Residential Habilitation

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Any provider of this service is required to attain and maintain a certification for this service from the Wyoming Department of Health, Behavioral Health Division.

Other Standard *(specify):*

An agency providing this service must meet the requirements in Wyoming Medicaid rules, Chapter 45, including assuring any employee providing this service successfully passes a Criminal History Background check, attains and maintains current CPR and First Aid Certification for all direct care staff, has employees certified in Medication Assistance for participants who need help with medications, has employees certified in crisis intervention and restraint usage(such as CPI or Mandt) if provider is serving participants with those possible needs, and has documentation on file that any employee in the agency transporting a participant has a current driver's license and automobile insurance. Agency direct care staff must also complete and document participant specific training before serving a participant, and complete and document general trainings on recognizing abuse and neglect, incident reporting, complaint process requirements, documentation standards, rights and rights restrictions, implementing the participant's objectives, and HIPAA & confidentiality requirements.

The Agency must adhere to the standards and requirements specified in Wyoming Medicaid Rules Chapter 45 and also meet all other the applicable Medicaid rules and regulations specified in the BHD Provider manual and provider agreement.

Verification of Provider Qualifications

Entity Responsible for Verification:

Behavioral Health Division

Frequency of Verification:

The Division initially certifies a new agency providing this service for one year and the agency is required to complete a recertification every year thereafter for the provision of this service. The Division has the authority to monitor agencies throughout their recertification period through the complaint process, incident reporting process, or internal referral process if there is indication the provider is not complying with the rules and regulations.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Residential Habilitation

Provider Category:
Individual

Provider Type:
Individual Hired by the participant for shared living (res hab)

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

The Fiscal/Employer Agent Financial Management Service verifies with documentation in a file that the individual being hired to provide this service:
- Is at least 18 years of age
- Has completed a successful criminal background check
- Has the ability to communicate effectively with the individual/family
- Has the ability to complete record keeping as required by the employer
- Has current CPR and First Aid Certification
- Has current Medication Assistance Training certification, if applicable
- Has Crisis Intervention and Restraint usage certification, such as CPI or Mandt, if applicable for participant's needs
- Has a current driver's license and automobile insurance if transporting the participant

The participant and/or legal representative, with assistance as needed from the Support Broker or case manager, verifies that, prior to working alone with the participant, the individual being hired demonstrates competence in knowledge of the following BHD policies and procedures:
- Recognizing abuse/neglect;
- Incident reporting;
- Participant rights and confidentiality;
- Emergency drills/situations;
- Documentation standards; and
- Demonstrates competence/knowledge in participants needs outlined in the individual plan of care

This individual may only serve up to 3 people in shared living and provide no other residential habilitation service to another participant. Within one year of being employed to provide this service, if providing services to someone who has restraints or restrictions on their plan, is required to successfully complete the Division training module on positive behavior supports.

Verification of Provider Qualifications

Entity Responsible for Verification:
Fiscal Employer Agent- Financial Management Service

Frequency of Verification:

Employees hired through the Financial Management Service are required to attain, maintain, and show evidence of a successful Criminal History background, current CPR and First Aid certification, medication assistance training (if applicable) current driver's license and vehicle insurance (if transporting participants), and current certification in crisis intervention and restraint usage (if applicable for the participant's needs) prior to being employed and providing waiver services.

The Fiscal Employer Agent - FMS inputs all employee information into a database, which shows each item that an employee has completed in order to qualify to provide services to a participant. Any documentation that has an expiration date is entered into their database as to the date of when it expires and flags them to notify the employee and employer of record and support broker when an item is expiring.

Once an employee shows that all documentation is submitted, the Fiscal Employer Agent – FMS database is updated and the FMS allows the employee to start work.

Fiscal Employer Agent – FMS also does quarterly reviews on a random sample of files to ensure that all required documents are submitted and logged correctly in the database and file.

The Agent provides a weekly status report to support brokers regarding provider certifications, paperwork, status of trainings, and whether or not the provider has met all requirements to work for a participant. The Agent also provides a monthly report to support brokers, which includes a status of upcoming training expirations of providers. The fiscal agent suspends all payments of a provider who lapses on their certification and notifies the provider and EOR.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Respite

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
09 Caregiver Support	09012 respite, in-home
Category 2:	**Sub-Category 2:**
09 Caregiver Support	09011 respite, out-of-home
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service

Definition *(Scope):*

Respite Service is intended to be utilized on a short-term, temporary basis for an unpaid caregiver or non-CARF residential provider to provide relief from the daily burdens of care. Respite service includes assistance with activities of daily living (ADL), medication assistance if needed, and supervision. Respite cannot be used during services otherwise available through public education programs including education activities, after school supervision, daytime services when the school is not in session, or services available to preschool age children.

It may be provided in the caregiver's home, the provider's home, or in community settings. Respite can only be provided for up to two people at the same time or up to three if members are in the same family and live in the same household (as long as all participants can be safely supported by one provider or unless the participant's plan of care requires an intensive support level).

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Respite is delivered as a 15-minute unit of service. The total number of 15 minute units available for respite per plan year is 1,664. The combined use of daily and 15-minute service cannot exceed an average of 8 hours a week of service over the plan year, which is equivalent to 416 hours a year. Respite cannot be used for day care purposes while the primary caregiver is working.

- Any use of respite over 9 hours a day must be billed as a daily unit.
- Approved amount of service is based upon the participant's need and budget limit, not to exceed 1664 units per plan year.
- Services provided must be provided as relief of the primary caregiver, should primarily be episodic in nature, and not used when parents or primary caregivers are working.
- Relative providers (excluding parents/stepparents) may provide this service.
- Respite services cannot be provided during the same time period as other waiver services, which is subject to audit by Medicaid.

A respite service provider or provider staff providing respite services:
- Cannot serve more than two waiver participants or up to three, if participants are in the same family and live in the same household (as long as all participants can be safely supported by one provider or unless the participant's plan of care requires an intensive support level).
- May also provide supervision to other children under the age of 12 or other individuals requiring support and supervision, but
- Must limit the total combined number of persons they are providing services to at a given time (both participants and other children under the age of 12 or other individuals requiring support and supervision) to no more three persons unless approved by the Division
- Must adhere to the supervision levels identified in each participant's plan of care

Respite services cannot not take the place of residential or day services. Transportation is included in the rate.

Respite services shall accommodate the needs of the participant. The respite site and services shall match the identified needs of the participant and family.

Service Delivery Method *(check each that applies)*:

- [x] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)*:

- [ ] **Legally Responsible Person**
- [x] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	CARF-accredited agency also certified by BHD for Respite
Individual	Individual Hired by the participant
Agency	Agency certified by BHD to provide Respite

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite

Provider Category:
Agency

Provider Type:
CARF-accredited agency also certified by BHD for Respite

Provider Qualifications

License *(specify)*:

Certificate *(specify)*:
Any provider of this service is required to attain and maintain a certification for this service from the Wyoming Department of Health, Behavioral Health Division. BHD requires a provider to attain and maintain accreditation by the Commission on Accreditation of Rehabilitative Facilities (CARF) or other nationally recognized accreditation entity for human services as specified in Chapter 45 the Wyoming Medicaid rules.

Other Standard *(specify)*:

An agency providing this service must meet the requirements in Wyoming Medicaid rules, Chapter 45, including assuring any employee providing this service successfully passes a Criminal History Background check, attains and maintains current CPR and First Aid Certification for all direct care staff, has employees certified in Medication Assistance for participants who need help with medications, has employees certified in crisis intervention and restraint usage(such as CPI or Mandt) if provider is serving participants with those possible needs, and has documentation on file that any employee in the agency transporting a participant has a current driver's license and automobile insurance. Agency direct care staff must also complete and document participant specific training before serving a participant, and complete and document general trainings on recognizing abuse and neglect, incident reporting, complaint process requirements, documentation standards, rights and rights restrictions, implementing the participant's objectives, and HIPAA & confidentiality requirements.

The Agency must adhere to the standards and requirements specified in Wyoming Medicaid Rules Chapter 45 and also meet all other the applicable Medicaid rules and regulations specified in the BHD Provider manual and provider agreement.

Verification of Provider Qualifications

Entity Responsible for Verification:

Behavioral Health Division

Frequency of Verification:

The Division initially certifies a CARF agency providing this service for one year and the agency is required to complete a recertification in all services provided every year thereafter. The Division has the authority to monitor agencies throughout their recertification period through the complaint process, incident reporting process, or internal referral process if there is indication the provider is not complying with the rules and regulations.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Individual

Provider Type:

Individual Hired by the participant

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

The Fiscal/Employer Agent Financial Management Service verifies with documentation in a file that the individual being hired to provide this service:

- Is at least 18 years of age
- Has completed a successful criminal background check
- Has the ability to communicate effectively with the individual/family
- Has the ability to complete record keeping as required by the employer
- Has current CPR and First Aid Certification
- Has current Medication Assistance Training certification, if applicable
- Has Crisis Intervention and Restraint usage certification, such as CPI or Mandt, if applicable for participant's needs
- Has a current driver's license and automobile insurance if transporting the participant

The participant and/or legal representative, with assistance as needed from the Support Broker or case manager, verifies that, prior to working alone with the participant, the individual being hired demonstrates competence in knowledge of the following BHD policies and procedures:

- Recognizing abuse/neglect;
- Incident reporting;
- Participant rights and confidentiality;
- Emergency drills/situations;
- Documentation standards; and
- Demonstrates competence/knowledge in participants needs outlined in the individual plan of care

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Employer Agent- Financial Management Service

Frequency of Verification:

Employees hired through the Financial Management Service are required to attain, maintain, and show evidence of a successful Criminal History background, current CPR and First Aid certification, current driver's license and vehicle insurance (if transporting participants), and current certification in crisis intervention and restraint usage (if applicable for the participant's needs) prior to being employed and providing waiver services.

The Fiscal Employer Agent - FMS inputs all employee information into a database, which shows each item that an employee has completed in order to qualify to provide services to a participant. Any documentation that has an expiration date is entered into their database as to the date of when it expires and flags them to notify the employee and employer of record and support broker when an item is expiring.

Once an employee shows that all documentation is submitted, the Fiscal Employer Agent – FMS database is updated and the FMS allows the employee to start work.

Fiscal Employer Agent – FMS also does quarterly reviews on a random sample of files to ensure that all required documents are submitted and logged correctly in the database and file.

The Agent provides a weekly status report to support brokers regarding provider certifications, paperwork, status of trainings, and whether or not the provider has met all requirements to work for a participant. The Agent also provides a monthly report to support brokers, which includes a status of upcoming training expirations of providers. The fiscal agent suspends all payments of a provider who lapses on their certification and notifies the provider and EOR.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Agency certified by BHD to provide Respite

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Any provider of this service is required to attain and maintain a certification for this service from the Wyoming Department of Health, Behavioral Health Division.

Other Standard *(specify):*

An agency providing this service must meet the requirements in Wyoming Medicaid rules, Chapter 45, including assuring any employee providing this service successfully passes a Criminal History Background check, attains and maintains current CPR and First Aid Certification for all direct care staff, has employees certified in Medication Assistance for participants who need help with medications, has employees certified in crisis intervention and restraint usage(such as CPI or Mandt) if provider is serving participants with those possible needs, and has documentation on file that any employee in the agency transporting a participant has a current driver's license and automobile insurance. Agency direct care staff must also complete and document participant specific training before serving a participant, and complete and document general trainings on recognizing abuse and neglect, incident reporting, complaint process requirements, documentation standards, rights and rights restrictions, implementing the participant's objectives, and HIPAA & confidentiality requirements.

The Agency must adhere to the standards and requirements specified in Wyoming Medicaid Rules Chapter 45 and also meet all other the applicable Medicaid rules and regulations specified in the BHD Provider manual and provider agreement.

Verification of Provider Qualifications

Entity Responsible for Verification:

Behavioral Health Division

Frequency of Verification:

BHD initially certifies an agency providing this service for one year and the agency is required to complete a recertification at the end of the first year. After the initial year certification, BHD may certify an agency in this service for up to two years. An agency, who receives a recommendation that identifies non-compliance with any rule and regulation pertaining to health, safety, rights or the standards for habilitation service provision may only receive up to a one-year recertification pending corrective action on the area of non-compliance. An agency, who does not receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation service standards may receive a two-year recertification. BHD has the authority to monitor agencies throughout their recertification period through the complaint process, incident reporting process, or internal referral process, if there is indication the agency is not complying with the rules and regulations.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Supported Employment

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:

03 Supported Employment

Sub-Category 1:

03010 job development

Category 2:

03 Supported Employment

Sub-Category 2:

03021 ongoing supported employment, individual

Category 3:

03 Supported Employment

Sub-Category 3:

03022 ongoing supported employment, group

Category 4:

03 Supported Employment

Sub-Category 4:

03030 career planning

Definition *(Scope):*

This waiver offers various employment support services to support and assist a participant who, because of their disability, needs intensive support to find and maintain a job in competitive, integrated work setting in the general workforce for which an individual is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by an individual without a disability. The outcome of using the employment pathway of support services is to help a participant find and maintain a job that meets personal and career goals.

A range of supported employment services are available with varying levels of support and intensity to assist the participant in attaining and maintaining the highest level of paid, community integrated employment. Consistent with the Olmstead decision and with person-centered planning, a participant's plan of care regarding employment services shall be constructed in a manner that reflects individual choice and goals relating to employment and ensures provision of services in the most integrated setting appropriate. Pathway services include:

- Prevocational Services (listed as a separate service on the waiver)
- Employment Discovery and Customization
- Small Group Supported Employment
- Individual Supported Employment
- Supported Employment Follow Along
- Transportation (listed as a separate service on the waiver)

Employment Discovery and Customization
Employment Discovery and Customization is the individualized determination of the strengths, needs, and interests of the participant and is designed to meet the specific needs of the employee and employer relationship. Employment discovery and customization includes employment developed through job carving, self-employment or entrepreneurial initiative, or other job development or restructuring strategies that result in job responsibilities being customized and individually negotiated to fit the needs of participants. Employment discovery and customization presumes the provision of reasonable accommodations and supports necessary to perform functions of a job that is individually negotiated and developed.

Employment discovery and customization is a 1:1 support service and has a limited time frame of 12 months.

Small Group Supported Employment
Small group supported employment services may be provided under a group rate for groups ranging from 2 to 9 persons. Group employment for groups larger than 9 people will not be reimbursed by the waiver. Small Group Supported Employment services consist of intensive, ongoing support that enable a participant, for whom competitive employment at or above the minimum wage is unlikely absent the provision of supports, and who, because of his/her disability, need supports to perform in a regular work setting, including mobile work crews or enclaves. Services are conducted in a variety of settings, particularly work sites where persons without disabilities are employed. Services include activities needed to sustain paid work by a participant, including supervision and training. When supported employment services are provided at a work site where persons without disabilities are employed, payment is made only for the adaptations; supervision and training required by participants receiving waiver services as a result of their disabilities but does not include payment for the supervisory activities rendered as a normal part of the business setting.

Objectives must be identified in the participant's plan that supports the need for continued job coaching with a plan to lessen the job coaching over time, if possible. The job coach must be in the immediate vicinity and available for immediate intervention and support. Small group supported employment can include employment in community businesses or businesses that are part of a provider organization.

Individual Supported Employment
Individual Supported Employment services are the 1:1 supports available to a participant who, because of their disability, needs intensive, sometimes on-going support, to obtain and maintain an individual job in competitive or customized employment, self-employment, in an integrated work setting in the general workforce for which an individual is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by an individual without a disability.

Services are conducted in a variety of settings, particularly work sites where persons without disabilities are employed. Services include activities needed to sustain paid work by a participant, including supervision and training. When supported employment services are provided at a work site where persons without disabilities are employed, payment is made only for the adaptations; supervision and training required by participants receiving waiver services as a result of their disabilities, but does not include payment for the supervisory activities rendered as a normal part of the business setting.

Objectives must be identified in the participant's plan that supports the need for continued job coaching with a plan to lessen the job coaching over time, if possible. Individual Supported Employment must be provided in a community employment setting, unless the support is to develop customized employment, self-employment, or home-based employment (subject to prior approval of the Division).

Supported Employment Follow along (SEFA)
Services and supports that enable a participant who is paid at or above the federal minimum wage to maintain employment in an integrated community employment setting. Service is provided for or on behalf of a participant through intermittent and occasional job support, communicating with the participant's supervisor or manager, whether in the presence of the participant or not. SEFA may cover support through phone calls between support staff and the participant's managerial staff. SEFA reimburses at a 15 minute rate for up to 100 units annually, with approved units based upon individual need in order to maintain employment.

SEFA does not reimburse for transportation, work crews, public relations, community education, in-service meetings, or individual staff development.

SEFA Reimbursable Activities:

- Time spent at the participant's work site: observation and supervision of the participant, teaching job tasks and monitoring at the work site a minimum of twice a month, to ascertain the success of the job placement
- A participant may receive SEFA for working in an integrated community work environment where at least 51% of other employees who work around the participant do not have disabilities
- The provision of skilled job trainers who accompany the participant for short-term job skill training at the work site to help maintain employment.
- Regular contact and/or follow-up with the employer and participant in order to reinforce and stabilize the job placement.
- Facilitation of natural supports at the work site.
- Individual program development, writing tasks analyses, monthly reviews, termination reviews and behavioral intervention programs.
- Advocating for the participant, but only with persons at the employment site (i.e., employers, co-workers, customers) and only for purposes directly related to employment.
- Staff time used in traveling to and from a work site.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Provider Category: Provider Type Title:

Employment Discovery services are reimbursed at a 15 minute rate. There is annual cap of 400 units, where 100 units will be authorized initially in order to develop a strengths, needs, and interest assessment and an employment plan. After submitting the employment plan, an additional 300 units may be approved to explore various types of job customization, self-employment, or entrepreneurial opportunities. Documentation for any supported employment service must be maintained in the provider and case manager's file for each participant receiving this service that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 (Vocational Rehabilitation or Workforce Services) or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq./school district). Services cannot be provided during the school hours set by the local school district.

Services approved must be based on participant need and fit within the person's assigned budget.

Documentation for any supported employment service must be maintained in the provider and case manager's file for each participant receiving this service that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 (Vocational Rehabilitation or Workforce Services) or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.) (school district). Services cannot be provided during the school hours set by the local school district.

Federal financial participation is not claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:
1. Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program;
2. Payments that are passed through to users of supported employment programs; or
3. Payments for training that is not directly related to a participant's supported employment program.

Relative providers (excluding parents/stepparents) may provide these services.

Transportation is not included in the reimbursement rates for this service.

SEFA
SEFA reimburses at a 15 minute rate for up to 100 units annual, with approved units based upon individual need in order to maintain employment.

SEFA does not reimburse for transportation, work crews, public relations, community education, in-service meetings, or individual staff development.

SEFA Non-reimbursable Activities:
- Transportation of an individual participant.
- Activities taking place in a group, i.e., work crews or enclaves.
- Public relations.
- Community education.
- In-service meetings, department meetings, individual staff development.
- Incentive payments made to an employer to subsidize the employer's participation in a supported employment program.
- Payments that are passed through to users of supported employment programs.
- Sheltered work observation.
- Payments for vocational training or activities that is not directly related to a participant's employment objective.
- Any other activities that are non-participant specific, such as a job coach working the job instead of the participant.
- Services furnished to a minor by a parent(s), step-parent(s) or legal guardian.
- Services furnished to a participant by the participant's spouse.

Service Delivery Method *(check each that applies)*:

- [x] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [ ] **Legally Responsible Person**
- [x] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	CARF-accredited agency also certified by BHD for Supported Employment Services
Agency	Agency certified to provide Supported Employment Services
Individual	Individual Hired by the participant to provide Individual supported employment

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Supported Employment

Provider Category:

Agency

Provider Type:

CARF-accredited agency also certified by BHD for Supported Employment Services

Provider Qualifications

License *(specify):*

Certificate *(specify):*

All providers of this service are required to attain and maintain a certification for this service from the Wyoming Department of Health, Behavioral Health Division.

BHD requires providers to attain and maintain accreditation by the Commission on Accreditation of Rehabilitative Facilities (CARF) or other nationally recognized accreditation entity for human services as specified in Chapter 45 the Wyoming Medicaid rules.

Other Standard *(specify):*

An agency providing this service must meet the requirements in Wyoming Medicaid rules, Chapter 45, including assuring any employee providing this service successfully passes a Criminal History Background check, attains and maintains current CPR and First Aid Certification for all direct care staff, has employees certified in Medication Assistance for participants who need help with medications, has employees certified in crisis intervention and restraint usage(such as CPI or Mandt) if provider is serving participants with those possible needs, and has documentation on file that any employee in the agency transporting a participant has a current driver's license and automobile insurance. Agency direct care staff must also complete and document participant specific training before serving a participant, and complete and document general trainings on recognizing abuse and neglect, incident reporting, complaint process requirements, documentation standards, rights and rights restrictions, implementing the participant's objectives, and HIPAA & confidentiality requirements.

Agencies must adhere to the standards and requirements specified in Wyoming Medicaid Rules Chapter 45 and also meet all other the applicable Medicaid rules and regulations specified in the BHD Provider manual and provider agreement.

Agencies providing this service shall have procedures in place to assure participants are involved in making informed employment-related decisions, participants are linked to services and community resources that enable them to achieve their employment objectives, participants are given information on local job opportunities, and participants' satisfaction with employment services is assessed on a regular basis.

Within one year of becoming certified in employment services, 1 staff person working at least 50% of their time as a job coach/developer must be certified in a nationally recognized supported employment curriculum approved by the Division if serving up to 10 participants in this service, and for every 10 participants after-one additional staff working at least 50% of their time job coach/developer must be certified.

Verification of Provider Qualifications

Entity Responsible for Verification:

Behavioral Health Division

Frequency of Verification:

The Division initially certifies a CARF agency providing this service for one year and the agency is required to complete a recertification in all services provided every year thereafter. The Division has the authority to monitor agencies throughout their recertification period through the complaint process, incident reporting process, or internal referral process if there is indication the provider is not complying with the rules and regulations.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Supported Employment

Provider Category:

Agency

Provider Type:

Agency certified to provide Supported Employment Services

Provider Qualifications

License *(specify):*

Certificate *(specify):*

All providers of this service are required to attain and maintain a certification for this service from the Wyoming Department of Health, Behavioral Health Division.

Other Standard *(specify):*

An agency providing this service must meet the requirements in Wyoming Medicaid rules, Chapter 45, including assuring any employee providing this service successfully passes a Criminal History Background check, attains and maintains current CPR and First Aid Certification for all direct care staff, has employees certified in Medication Assistance for participants who need help with medications, has employees certified in crisis intervention and restraint usage (such as CPI or Mandt) if provider is serving participants with those possible needs, and has documentation on file that any employee in the agency transporting a participant has a current driver's license and automobile insurance. Agency direct care staff must also complete and document participant specific training before serving a participant, and complete and document general trainings on recognizing abuse and neglect, incident reporting, complaint process requirements, documentation standards, rights and rights restrictions, implementing the participant's objectives, and HIPAA & confidentiality requirements.

Agencies must adhere to the standards and requirements specified in Wyoming Medicaid Rules Chapter 45 and also meet all other the applicable Medicaid rules and regulations specified in the BHD Provider manual and provider agreement.

Agencies providing this service shall have procedures in place to assure participants are involved in making informed employment-related decisions, participants are linked to services and community resources that enable them to achieve their employment objectives, participants are given information on local job opportunities, and participants' satisfaction with employment services is assessed on a regular basis.

Within one year of becoming certified in employment services, 1 staff person working at least 50% of their time as a job coach/developer must be certified in a nationally recognized supported employment curriculum approved by the Division if serving up to 10 participants in this service, and for every 10 participants after-one additional staff working at least 50% of their time job coach/developer must be certified.

Verification of Provider Qualifications

Entity Responsible for Verification:

Behavioral Health Division

Frequency of Verification:

BHD initially certifies an agency providing this service for one year and the agency is required to complete a recertification at the end of the first year. After the initial year certification, BHD may certify an agency in this service for up to two years. An agency, who receives a recommendation that identifies non-compliance with any rule and regulation pertaining to health, safety, rights or the standards for habilitation service provision may only receive up to a one-year recertification pending corrective action on the area of non-compliance. An agency, who does not receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation service standards may receive a two-year recertification. BHD has the authority to monitor agencies throughout their recertification period through the complaint process, incident reporting process, or internal referral process, if there is indication the agency is not complying with the rules and regulations.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Supported Employment

Provider Category:

Individual

Provider Type:

Individual Hired by the participant to provide Individual supported employment

Provider Qualifications

License *(specify):*

Certificate *(specify):*

The Fiscal/Employer Agent Financial Management Service verifies with documentation in a file that the individual being hired to provide this service:
- Is at least 18 years of age
- Has completed a successful criminal background check
- Has the ability to communicate effectively with the individual/family
- Has the ability to complete record keeping as required by the employer
- Has current CPR and First Aid Certification
- Has current Medication Assistance Training certification, if applicable
- Has Crisis Intervention and Restraint usage certification, such as CPI or Mandt, if applicable for participant's needs
- Has a current driver's license and automobile insurance if transporting the participant

The participant and/or legal representative, with assistance as needed from the Support Broker or case manager, verifies that, prior to working alone with the participant, the individual being hired demonstrates competence in knowledge of the following BHD policies and procedures:
- Recognizing abuse/neglect;
- Incident reporting;
- Participant rights and confidentiality;
- emergency drills/situations;
- Documentation standards; and
- Demonstrates competence/knowledge in participants needs outlined in the individual plan of care

Other Standard *(specify):*

The Fiscal/Employer Agent FMS or Agency with Choice FMS verifies that the individual being hired:

• Is at least 18 yrs of age
• Has completed a successful criminal background check
• Has completed a successful Central Registry check
• Has the ability to communicate effectively with the individual/family
• Has the ability to complete record keeping as required by the employer
• Has current CPR and First Aid Certification
• Has a current driver's license and automobile insurance if transporting the participant

The participant and/or legal representative, with assistance as needed from the Support Broker, verifies that, prior to working alone with the participant, the individual being hired:

• Demonstrates competence in knowledge of the following DD Division policies and procedures: recognizing abuse/neglect; incident reporting; participant rights and confidentiality; emergency drills/situations,
• Demonstrates competence/knowledge in participants needs outlined in the individual plan of care

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal/Employer Agent FMS

Frequency of Verification:

Employees hired through the Financial Management Service are required to attain, maintain, and show evidence of a successful Central Abuse Registry Screening, a successful Criminal History background, current CPR and First Aid certification, current driver's license and vehicle insurance (if transporting participants), and current certification in crisis intervention and restraint usage (if applicable for the participant's needs) prior to being employed and providing waiver services.

The Fiscal Employer Agent - FMS inputs all employee information into a database, which shows each item that an employee has completed in order to qualify to provide services to a participant. Any documentation that has an expiration date is entered into their database as to the date of when it expires and flags them to notify the employee and employer of record and support broker when an item is expiring.

Once an employee shows that all documentation is submitted, the Fiscal Employer Agent – FMS database is updated and the FMS allows the employee to start work.

Fiscal Employer Agent – FMS also does quarterly reviews on a random sample of files to ensure that all required documents are submitted and logged correctly in the database and file.

The Agent provides a weekly status report to support brokers regarding provider certifications, paperwork, status of trainings, and whether or not the provider has met all requirements to work for a participant. The Agent also provides a monthly report to support brokers, which includes a status of upcoming training expirations of providers. The fiscal agent suspends all payments of a provider who lapses on their certification and notifies the provider and EOR.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Provider Category	Provider Type Title

Service Type:
Statutory Service

Service:
Habilitation

Alternate Service Title (if any):
Supported Living

HCBS Taxonomy:

Category 1:
08 Home-Based Services

Sub-Category 1:
08010 home-based habilitation

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service

Definition *(Scope):*
Supported Living services assist a participant to live in a home or apartment leased by the participant or guardian, or in the family's private home when the participant requires a range of community-based support to live as independently as possible. Supported Living Service provides individually tailored supports to assist with the acquisition, retention, or improvement in skills related to living successfully in the community. Supported Living Services are based on need and include assisting with common use of the community's transportation system; teaching the use of police, fire, and emergency assistance; performing routine household activities to maintain a clean and safe home; assistance with health issues, medications, and medical services; managing personal financial affairs; building and maintaining interpersonal relationships; participating in community life, and 24-hour emergency assistance.
- Supported Living Service includes personal care, therefore personal care services cannot be provided at the same time as supported living services.
- Relative providers may provide all components of this service as defined with the following limitations:
  - A relative (excluding parents/stepparents/legal authorized representatives) may provide this service to the participant while residing in the same residence as the participant.
  - A relative, who is a parent/stepparent, and a certified provider and LLC or a corporation or an employee of a certified provider, may provide this service as defined but shall not live or reside in the same residence as the participant.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
- Supported Living Service daily rate is based on 7 hours of service a day and a provider must provide a minimum of 4 hours of documented service per calendar day for reimbursement. One staff or provider can be reimbursed for providing services for up to 3 participants during one period of time.
- Supported Living Service can also be billed at a 15-minute unit rate for a maximum of 5,400 units per plan year for services provided to a group up to two or three participants, or 3,900 15-minute units per plan year provided to an individual participant.
- Supported living is a habilitation service, which means training on objectives is expected as part of the provision of services and objective progress must be reported to the participant, guardian, and case manager monthly.
- The plan of care must identify either the daily unit or the individual or group 15-minute unit, based on the participant's need. Both the daily unit and a 15 minute unit may be on the participant's plan of care but cannot be used on the same day.
- Transportation is included in the reimbursement rate for this service.

Service Delivery Method *(check each that applies)*:

- [x] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [ ] **Legally Responsible Person**
- [x] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individual Hired by the participant
Agency	CARF-accredited agency also certified by BHD for Supported Living

Provider Category	Provider Type Title
Agency	Agency certified by BHD to provide Supported Living

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Supported Living

Provider Category:

Individual

Provider Type:

Individual Hired by the participant

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

The Fiscal/Employer Agent Financial Management Service verifies with documentation in a file that the individual being hired to provide this service:

- Is at least 18 years of age
- Has completed a successful criminal background check
- Has the ability to communicate effectively with the individual/family
- Has the ability to complete record keeping as required by the employer
- Has current CPR and First Aid Certification
- Has current Medication Assistance Training certification, if applicable
- Has Crisis Intervention and Restraint usage certification, such as CPI or Mandt, if applicable for participant's needs
- Has a current driver's license and automobile insurance if transporting the participant

The participant and/or legal representative, with assistance as needed from the Support Broker or case manager, verifies that, prior to working alone with the participant, the individual being hired demonstrates competence in knowledge of the following BHD policies and procedures:

- Recognizing abuse/neglect;
- Incident reporting;
- Participant rights and confidentiality;
- Emergency drills/situations;
- Documentation standards; and
- Demonstrates competence/knowledge in participants needs outlined in the individual plan of care

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Employer Agent- Financial Management Service

Frequency of Verification:

Employees hired through the Financial Management Service are required to attain, maintain, and show evidence of a successful Criminal History background, current CPR and First Aid certification, current driver's license and vehicle insurance (if transporting participants), and current certification in crisis intervention and restraint usage (if applicable for the participant's needs) prior to being employed and providing waiver services.
The Fiscal Employer Agent - FMS inputs all employee information into a database, which shows each item that an employee has completed in order to qualify to provide services to a participant. Any documentation that has an expiration date is entered into their database as to the date of when it expires and flags them to notify the employee and employer of record and support broker when an item is expiring.
Once an employee shows that all documentation is submitted, the Fiscal Employer Agent – FMS database is updated and the FMS allows the employee to start work.

Fiscal Employer Agent – FMS also does quarterly reviews on a random sample of files to ensure that all required documents are submitted and logged correctly in the database and file.

The Agent provides a weekly status report to support brokers regarding provider certifications, paperwork, status of trainings, and whether or not the provider has met all requirements to work for a participant. The Agent also provides a monthly report to support brokers, which includes a status of upcoming training expirations of providers. The fiscal agent suspends all payments of a provider who lapses on their certification and notifies the provider and EOR.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Supported Living

Provider Category:

Agency

Provider Type:

CARF-accredited agency also certified by BHD for Supported Living

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Any provider of this service is required to attain and maintain a certification for this service from the Wyoming Department of Health, Behavioral Health Division. BHD requires a provider to attain and maintain accreditation by the Commission on Accreditation of Rehabilitative Facilities (CARF) or other nationally recognized accreditation entity for human services as specified in Chapter 45 the Wyoming Medicaid rules.

Other Standard *(specify):*

An agency providing this service must meet the requirements in Wyoming Medicaid rules, Chapter 45, including assuring any employee providing this service successfully passes a Criminal History Background check, attains and maintains current CPR and First Aid Certification for all direct care staff, has employees certified in Medication Assistance for participants who need help with medications, has employees certified in crisis intervention and restraint usage(such as CPI or Mandt) if provider is serving participants with those possible needs, and has documentation on file that any employee in the agency transporting a participant has a current driver's license and automobile insurance. Agency direct care staff must also complete and document participant specific training before serving a participant, and complete and document general trainings on recognizing abuse and neglect, incident reporting, complaint process requirements, documentation standards, rights and rights restrictions, implementing the participant's objectives, and HIPAA & confidentiality requirements.
The Agency must adhere to the standards and requirements specified in Wyoming Medicaid Rules Chapter 45 and also meet all other the applicable Medicaid rules and regulations specified in the BHD Provider manual and provider agreement.

Verification of Provider Qualifications

Entity Responsible for Verification:

Behavioral Health Division

Frequency of Verification:

The Division initially certifies a CARF agency providing this service for one year and the agency is required to complete a recertification in all services provided every year thereafter. The Division has the authority to monitor agencies throughout their recertification period through the complaint process, incident reporting process, or internal referral process if there is indication the provider is not complying with the rules and regulations.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Supported Living

Provider Category:

Agency

Provider Type:

Agency certified by BHD to provide Supported Living

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Any provider of this service is required to attain and maintain a certification for this service from the Wyoming Department of Health, Behavioral Health Division.

Other Standard *(specify):*

An agency providing this service must meet the requirements in Wyoming Medicaid rules, Chapter 45, including assuring any employee providing this service successfully passes a Criminal History Background check, attains and maintains current CPR and First Aid Certification for all direct care staff, has employees certified in Medication Assistance for participants who need help with medications, has employees certified in crisis intervention and restraint usage(such as CPI or Mandt) if provider is serving participants with those possible needs, and has documentation on file that any employee in the agency transporting a participant has a current driver's license and automobile insurance. Agency direct care staff must also complete and document participant specific training before serving a participant, and complete and document general trainings on recognizing abuse and neglect, incident reporting, complaint process requirements, documentation standards, rights and rights restrictions, implementing the participant's objectives, and HIPAA & confidentiality requirements.
The Agency must adhere to the standards and requirements specified in Wyoming Medicaid Rules Chapter 45 and also meet all other the applicable Medicaid rules and regulations specified in the BHD Provider manual and provider agreement.

Verification of Provider Qualifications

Entity Responsible for Verification:

Behavioral Health Division

Frequency of Verification:

The Division initially certifies a new agency providing this service for one year and the agency is required to complete a recertification every year thereafter for the provision of this service. The Division has the authority to monitor agencies throughout their recertification period through the complaint process, incident reporting process, or internal referral process if there is indication the provider is not complying with the rules and regulations.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Extended State Plan Service

Service Title:

Occupational Therapy

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
11 Other Health and Therapeutic Services	11080 occupational therapy
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service

Definition *(Scope)*:

Occupational Therapy services consist of the full range of activities provided by a licensed occupational therapist. Services include assessing needs, development a treatment plan, determining therapeutic intervention, training and assisting with adaptive aids. Occupational Services through the waiver can be used for maintenance and the prevention of regression of skills.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

The units must be prior authorized and must be prescribed by a physician. Occupational therapy Services on the Medicaid State Plan are limited to restorative therapy only. Maintenance therapy may be provided under the waiver. These services are uniquely coded. Edits to MMIS prohibit both restorative and maintenance therapy from being billed on the same day. Relative providers shall not provide this service.

Service is available as an individual 15 minute unit or as a group session unit which requires a minimum of 30 minutes in service in order to bill.

Service Delivery Method *(check each that applies)*:

Provider Category	Provider Type Title
Participant-directed as specified in Appendix E	

Provider managed

Specify whether the service may be provided by *(check each that applies)*:

- **Legally Responsible Person**
- **Relative**
- **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Home Health Agency certified to provide occupational therapy services
Agency	Agency certified to provide occupational therapy services

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service
Service Name: Occupational Therapy

Provider Category:

Agency

Provider Type:

Home Health Agency certified to provide occupational therapy services

Provider Qualifications

License *(specify):*

Medicare certified or state licensed Home Health Agency fully licensed in Wyoming.

Agencies certified to provide Occupational Therapy are required to verify that staff providing Occupational Therapy have a current license to practice Occupational Therapy by the Wyoming Board of Occupational Therapy as specified in Chapter 45 of Wyoming Medicaid Rules.

Certificate *(specify):*

Any provider of this service is required to attain and maintain a certification for this service from the Wyoming Department of Health, Behavioral Health Division.

Other Standard *(specify):*

An agency providing this service must meet the requirements in Wyoming Medicaid rules, Chapter 45, including assuring any employee providing this service successfully passes a Criminal History Background check, attains and maintains current CPR and First Aid Certification for all direct care staff, and has documentation on file that any employee in the agency transporting a participant has a current driver's license and automobile insurance. Agency direct care staff must also complete and document participant specific training before serving a participant, and complete and document general trainings on recognizing abuse and neglect, incident reporting, complaint process requirements, documentation standards, rights and rights restrictions, implementing the participant's objectives, and HIPAA & confidentiality requirements.

The Agency must adhere to the standards and requirements specified in Wyoming Medicaid Rules Chapter 45 and also meet all other the applicable Medicaid rules and regulations specified in the BHD Provider manual and provider agreement.

Verification of Provider Qualifications

Entity Responsible for Verification:

Behavioral Health Division

Frequency of Verification:

BHD initially certifies an agency providing this service for one year and the agency is required to complete a recertification at the end of the first year. After the initial year certification, BHD may certify an agency in this service for up to three years. An agency, who receives a recommendation that identifies non-compliance with any rule and regulation pertaining to health, safety, rights or the standards for habilitation service provision may only receive up to a one-year recertification pending corrective action on the area of non-compliance. An agency, who does not receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation service standards may receive a three-year recertification. BHD has the authority to monitor agencies throughout their recertification period through the complaint process, incident reporting process, or internal referral process, if there is indication the agency is not complying with the rules and regulations.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service

Service Name: Occupational Therapy

Provider Category:

Agency

Provider Type:

Agency certified to provide occupational therapy services

Provider Qualifications

License *(specify):*

Individuals certified to provide occupational therapy services must have a current license to practice Occupational therapy by the Wyoming Board of Occupational Therapy per Wyoming Medicaid Rules, Chapter 45.

Certificate *(specify):*

Any provider of this service is required to attain and maintain a certification for this service from the Wyoming Department of Health, Behavioral Health Division.

Other Standard *(specify):*

An agency providing this service must meet the requirements in Wyoming Medicaid rules, Chapter 45, including assuring any employee providing this service successfully passes a Criminal History Background check, attains and maintains current CPR and First Aid Certification for all direct care staff, and has documentation on file that any employee in the agency transporting a participant has a current driver's license and automobile insurance. Agency direct care staff must also complete and document participant specific training before serving a participant, and complete and document general trainings on recognizing abuse and neglect, incident reporting, complaint process requirements, documentation standards, rights and rights restrictions, implementing the participant's objectives, and HIPAA & confidentiality requirements.

The Agency must adhere to the standards and requirements specified in Wyoming Medicaid Rules Chapter 45 and also meet all other the applicable Medicaid rules and regulations specified in the BHD Provider manual and provider agreement.

Verification of Provider Qualifications

Entity Responsible for Verification:

Behavioral Health Division

Frequency of Verification:

BHD initially certifies an agency providing this service for one year and the agency is required to complete a recertification at the end of the first year. After the initial year certification, BHD may certify an agency in this service for up to three years. An agency, who receives a recommendation that identifies non-compliance with any rule and regulation pertaining to health, safety, rights or the standards for habilitation service provision may only receive up to a one-year recertification pending corrective action on the area of non-compliance. An agency, who does not receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation service standards may receive a three-year recertification. BHD has the authority to monitor agencies throughout their recertification period through the complaint process, incident reporting process, or internal referral process, if there is indication the agency is not complying with the rules and regulations.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Extended State Plan Service

Service Title:

Physical Therapy

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
11 Other Health and Therapeutic Services	11090 physical therapy
Category 2:	**Sub-Category 2:**
11 Other Health and Therapeutic Services	11080 occupational therapy
Category 3:	**Sub-Category 3:**

Provider Category	Provider Type Title

Service

Category 4:

Sub-Category 4:

Definition *(Scope):*

Physical Therapy services consist of the full range of activities provided by a licensed physical therapist. This service assists individuals to preserve and improve their abilities for independent function such as range of motion, strength, tolerance, and coordination. It may also prevent, insofar as possible, irreducible or progressive disabilities through the use of assistive and adaptive devices, positioning, and sensory stimulation.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Services through the waiver can be used for maintenance and the prevention of regression of skills. The units must be prior authorized and must be prescribed by a physician. Physical Therapy services on the Medicaid State Plan are limited to restorative only. Services provided under the state plan must be utilized to the extent they are allowed. The state plan covers some visits each year and the cap can be exceed with justification from a qualifying medical professional when they are restorative. These services are uniquely coded. Edits to MMIS prohibit both restorative and maintenance therapy from being billed on the same day. Relative providers shall not provide this service.

Service is available as an individual 15 minute unit or as a group session unit. The group unit is under a combined Service Title of "Occupational/Physical Therapy Group" that requires a minimum of 30 minutes in service in order to bill.

Service Delivery Method *(check each that applies)*:

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agency certified by BHD to provide Physical Therapy
Agency	Home Health Agency certified to provide Physical Therapy

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service
Service Name: Physical Therapy

Provider Category:

Agency

Provider Type:

Agency certified by BHD to provide Physical Therapy

Provider Qualifications

License *(specify):*

Agencies certified to provide Physical Therapy are required to verify staff providing Physical Therapy have a current license to practice physical therapy by the Wyoming Board of Physical Therapy per Wyoming Medicaid Rules, Chapter 45.

Certificate *(specify):*

Any provider of this service is required to attain and maintain a certification for this service from the Wyoming Department of Health, Behavioral Health Division.

Other Standard *(specify):*

An agency providing this service must meet the requirements in Wyoming Medicaid rules, Chapter 45, including assuring any employee providing this service successfully passes a Criminal History Background check, attains and maintains current CPR and First Aid Certification for all direct care staff, and has documentation on file that any employee in the agency transporting a participant has a current driver's license and automobile insurance. Agency direct care staff must also complete and document participant specific training before serving a participant, and complete and document general trainings on recognizing abuse and neglect, incident reporting, complaint process requirements, documentation standards, rights and rights restrictions, implementing the participant's objectives, and HIPAA & confidentiality requirements.
The Agency must adhere to the standards and requirements specified in Wyoming Medicaid Rules Chapter 45 and also meet all other the applicable Medicaid rules and regulations specified in the BHD Provider manual and provider agreement.

Verification of Provider Qualifications

Entity Responsible for Verification:

Behavioral Health Division

Frequency of Verification:

BHD initially certifies an agency providing this service for one year and the agency is required to complete a recertification at the end of the first year. After the initial year certification, BHD may certify an agency in this service for up to three years. An agency, who receives a recommendation that identifies non-compliance with any rule and regulation pertaining to health, safety, rights or the standards for habilitation service provision may only receive up to a one-year recertification pending corrective action on the area of non-compliance. An agency, who does not receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation service standards may receive a three-year recertification. BHD has the authority to monitor agencies throughout their recertification period through the complaint process, incident reporting process, or internal referral process, if there is indication the agency is not complying with the rules and regulations.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service
Service Name: Physical Therapy

Provider Category:

Agency

Provider Type:

Home Health Agency certified to provide Physical Therapy

Provider Qualifications

License *(specify):*

Medicare certified or state licensed Home Health Agency fully licensed in Wyoming. Agencies certified to provide Physical Therapy are required to verify staff providing Physical Therapy have a current license to practice physical therapy by the Wyoming Board of Physical Therapy per Wyoming Medicaid Rules, Chapter 45.

Certificate *(specify):*

Any provider of this service is required to attain and maintain a certification for this service from the Wyoming Department of Health, Behavioral Health Division.

Other Standard *(specify):*

An agency providing this service must meet the requirements in Wyoming Medicaid rules, Chapter 45, including assuring any employee providing this service successfully passes a Criminal History Background check, attains and maintains current CPR and First Aid Certification for all direct care staff, and has documentation on file that any employee in the agency transporting a participant has a current driver's license and automobile insurance. Agency direct care staff must also complete and document participant specific training before serving a participant, and complete and document general trainings on recognizing abuse and neglect, incident reporting, complaint process requirements, documentation standards, rights and rights restrictions, implementing the participant's objectives, and HIPAA & confidentiality requirements.
The Agency must adhere to the standards and requirements specified in Wyoming Medicaid Rules Chapter 45 and also meet all other the applicable Medicaid rules and regulations specified in the BHD Provider manual and provider agreement.

Verification of Provider Qualifications

Entity Responsible for Verification:

Behavioral Health Division

Frequency of Verification:

BHD initially certifies an agency providing this service for one year and the agency is required to complete a recertification at the end of the first year. After the initial year certification, BHD may certify an agency in this service for up to three years. An agency, who receives a recommendation that identifies non-compliance with any rule and regulation pertaining to health, safety, rights or the standards for habilitation service provision may only receive up to a one-year recertification pending corrective action on the area of non-compliance. An agency, who does not receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation service standards may receive a three-year recertification. BHD has the authority to monitor agencies throughout their recertification period through the complaint process, incident reporting process, or internal referral process, if there is indication the agency is not complying with the rules and regulations.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Extended State Plan Service

Service Title:

Speech, Hearing and Language Services

HCBS Taxonomy:

Provider Category	Provider Type Title

Category 1: 11 Other Health and Therapeutic Services

Sub-Category 1: 11100 speech, hearing, and language therapy

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service

Definition *(Scope)*:

Speech, Hearing and Language services consist of the full range of activities provided by a licensed speech therapist. Services include screening and evaluation of participants with respect to speech function; development of therapeutic treatment plans; direct therapeutic intervention; selection, assistance, and training with augmentative communication devices, and the provision of ongoing therapy.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

A minimum of 45 minutes of service per session must be provided in order to bill. The service may be conducted as an individual 1:1 service session or in a group session, with the specific rates for each type. Services through the waiver can be used for maintenance and the prevention of regression of skills. The units must be prior authorized and must be prescribed by a physician. Speech and Hearing services under the Medicaid State Plan are limited to restorative only. Maintenance therapy may be provided under the waiver. These services are uniquely coded. Edits to MMIS prohibit both restorative and maintenance therapy from being billed on the same day. Relative providers shall not provide this service.

Service Delivery Method *(check each that applies)*:

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)*:

- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Home Health Agency certified to provide Speech, Hearing and Language Services
Agency	Agency certified by BHD to provide Speech, Hearing and Language Services

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service
Service Name: Speech, Hearing and Language Services

Provider Category:
Agency

Provider Type:
Home Health Agency certified to provide Speech, Hearing and Language Services

Provider Qualifications

License *(specify)*:

Medicare certified or state licensed Home Health Agency fully licensed in Wyoming.

Agencies certified in this service are required to verify staff providing Speech, Hearing and Language Services have a current license to practice Speech, Hearing and Language Services by the Wyoming Board of Speech Pathology and Audiology per Wyoming Medicaid Rules, Chapter 45.

Certificate *(specify):*

Any provider of this service is required to attain and maintain a certification for this service from the Wyoming Department of Health, Behavioral Health Division.

Other Standard *(specify):*

An agency providing this service must meet the requirements in Wyoming Medicaid rules, Chapter 45, including assuring any employee providing this service successfully passes a Criminal History Background check, attains and maintains current CPR and First Aid Certification for all direct care staff, and has documentation on file that any employee in the agency transporting a participant has a current driver's license and automobile insurance. Agency direct care staff must also complete and document participant specific training before serving a participant, and complete and document general trainings on recognizing abuse and neglect, incident reporting, complaint process requirements, documentation standards, rights and rights restrictions, implementing the participant's objectives, and HIPAA & confidentiality requirements.
The Agency must adhere to the standards and requirements specified in Wyoming Medicaid Rules Chapter 45 and also meet all other the applicable Medicaid rules and regulations specified in the BHD Provider manual and provider agreement.

Verification of Provider Qualifications

Entity Responsible for Verification:

Behavioral Health Division

Frequency of Verification:

BHD initially certifies an agency providing this service for one year and the agency is required to complete a recertification at the end of the first year. After the initial year certification, BHD may certify an agency in this service for up to three years. An agency, who receives a recommendation that identifies non-compliance with any rule and regulation pertaining to health, safety, rights or the standards for habilitation service provision may only receive up to a one-year recertification pending corrective action on the area of non-compliance. An agency, who does not receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation service standards may receive a three-year recertification. BHD has the authority to monitor agencies throughout their recertification period through the complaint process, incident reporting process, or internal referral process, if there is indication the agency is not complying with the rules and regulations.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service
Service Name: Speech, Hearing and Language Services

Provider Category:

Agency

Provider Type:

Agency certified by BHD to provide Speech, Hearing and Language Services

Provider Qualifications

License *(specify):*

Agencies certified to provide Speech, Hearing and Language Services are required to verify staff providing Speech, Hearing and Language Services have a current license to practice Speech, Hearing and Language Services by the Wyoming Board of Speech Pathology and Audiology per Wyoming Medicaid Rules, Chapter 45.

Certificate *(specify):*

Any provider of this service is required to attain and maintain a certification for this service from the Wyoming Department of Health, Behavioral Health Division.

Other Standard *(specify):*

An agency providing this service must meet the requirements in Wyoming Medicaid rules, Chapter 45, including assuring any employee providing this service successfully passes a Criminal History Background check, attains and maintains current CPR and First Aid Certification for all direct care staff, and has documentation on file that any employee in the agency transporting a participant has a current driver's license and automobile insurance. Agency direct care staff must also complete and document participant specific training before serving a participant, and complete and document general trainings on recognizing abuse and neglect, incident reporting, complaint process requirements, documentation standards, rights and rights restrictions, implementing the participant's objectives, and HIPAA & confidentiality requirements.
The Agency must adhere to the standards and requirements specified in Wyoming Medicaid Rules Chapter 45 and also meet all other the applicable Medicaid rules and regulations specified in the BHD Provider manual and provider agreement.

Verification of Provider Qualifications

Entity Responsible for Verification:

Behavioral Health Division

Frequency of Verification:

BHD initially certifies an agency providing this service for one year and the agency is required to complete a recertification at the end of the first year. After the initial year certification, BHD may certify an agency in this service for up to three years. An agency, who receives a recommendation that identifies non-compliance with any rule and regulation pertaining to health, safety, rights or the standards for habilitation service provision may only receive up to a one-year recertification pending corrective action on the area of non-compliance. An agency, who does not receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation service standards may receive a three-year recertification. BHD has the authority to monitor agencies throughout their recertification period through the complaint process, incident reporting process, or internal referral process, if there is indication the agency is not complying with the rules and regulations.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Supports for Participant Direction

The waiver provides for participant direction of services as specified in Appendix E. Indicate whether the waiver includes the following supports or other supports for participant direction.

Support for Participant Direction:

Information and Assistance in Support of Participant Direction

Alternate Service Title (if any):

Independent Support Broker

HCBS Taxonomy:

Category 1:

12 Services Supporting Self-Direction

Sub-Category 1:

12020 information and assistance in support of self-direction

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service

Category 4:

Sub-Category 4:

Definition *(Scope):*

Provider Category Provider Type Title

Independent Support Brokerage assists the participant (and their participant's legal representative, as appropriate) in arranging for, directing and managing services. Serving as the agent of the participant or legal representative, the service is available to assist in identifying immediate and long-term needs, developing options to meet those needs and accessing identified supports and services. The Support Broker offers practical skills training to participants and their legal representatives to enable them to independently direct and manage waiver services. Support Brokers serve at the discretion of the participant and/or their legal representative. Examples of skills training include providing information on recruiting and hiring direct care workers, managing workers and providing information on effective communication and problem-solving. The service includes providing information to ensure that participants understand the responsibilities involved with directing their services. The extent of the assistance furnished to the participant or family is specified in the individual plan of care. This service does not duplicate other waiver services, including case management. Other functions include assisting the participant in:

1. Identifying immediate and long-term needs, preferences, goals and objectives of the participant for developing the individual plan of care.
2. Making decisions about the individual budget.
3. Developing options to meet the identified needs and access community services and supports specified in the individual plan of care.
4. Negotiating rates of payments and written agreements with service providers.
5. Selecting, hiring and training service providers, as applicable.
6. Developing and implementing risk management agreements and emergency back-up plans.
7. Conducting self-advocacy and assisting with employee grievances and complaints.
8. Assisting with filing grievances and complaints to outside entities, including the appropriate Financial Management Service provider and/or Division.
9. Providing information and practical skills training to the participant in the following areas:

a. Person-centered planning and its application.
b. The range and scope of individual choices and options.
c. The process for changing the individual plan of care and individual budget.
d. Recruitment and hiring of service workers.
e. Management of service workers, including effectively directing, communicating, and problem-solving.
f. Participant responsibilities in self-directed services, including the appeal process.
g. Recognition and reporting of abuse, neglect, and exploitation.

Support Brokers have responsibility for training all of the participant's employees on the Policy on Reportable Incidents and ensuring that all incidents meeting the criteria of the Division's Notification of Incident Process are reported. Support Brokers must review employee time sheets and monthly Fiscal Management Service (FMS) reports to ensure that the individualized budget is being spent in accordance with the approved Individual Plan and Budget, and coordinate follow-up on concerns with the participant's case manager. Support Brokerage is a waiver service that is funded through the participant's individual budget.

Support Brokerage is an optional service for a participant or legally authorized representative who self-directs services. If an EOR is struggling with self-directing responsibilities, the Division may require a Support Broker to be added to the person's plan of care in order to continue to self-direct. After a year of required support brokerage, the participant or representative may opt out of support broker services if he/she meets one of the criteria below and submits a formal request to opt out of Support Broker Services.

Criteria for Opting out of Support Broker Services includes the following, which is captured on an assessment tool completed by the case manager and approved by the Division:

1. Participants or their legal representatives who are self-directing through the Financial Management Service who demonstrate the ability to choose workers, coordinate the hiring of workers through the Financial Management Service provider, and coordinate the delivery of services with the FMS provider.
2. Participants or their legal representatives who have successfully self-directed services for one year with no concerns, including hiring, firing, training, scheduling workers and reviewing timesheets in a timely manner.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service is a 15-minute unit. There is annual cap of 320 units. IBAs will not be increased to add this service. The Division's ECC process can look at the need and adjust the budget accordingly. If a person is at their budget limit, they likely will not be able to have an increase to their budget for a new service unless there is health and safety issues. If necessary, the support broker requirement will be required the next plan cycle and the division and case manager will help monitor self-direction activities until the new plan can start.

Relatives can be a support broker to their related waiver participant, if they are a certified support provider and provide no other service to the participant on their plan. However, a parent/stepparent/legal guardian acting as a support broker cannot be reimbursed. They can be an unpaid support broker for the participant and are subject to the same qualification and monitoring requirements as paid support brokers.

All paid Support Brokers shall be free of any conflict of interest including employment with a certified waiver provider or provision of any other Waiver service to the same participant. An Individual Support Broker hired by the participant shall only serve one participant, unless he/she is chosen to serve one additional sibling in the same household.

If a participant is hiring a parent/stepparent/legal guardian as an employee of a direct care services, such as respite or personal care, then the participant shall not opt out of support brokerage and must have an actively involved unrelated support broker to ensure that the s/he has engaged in recruitment activities and that there is a responsible person other than the paid parent, who, in addition to the participant, assumes employer responsibilities.

Service Delivery Method *(check each that applies)*:

- [x] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)*:

- [ ] **Legally Responsible Person**
- [x] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	CARF-accredited agency also certified by BHD for Independent Support Brokerage

Provider Category	Provider Type Title
Agency	Agency certified by BHD for Independent Support Brokerage
Individual	Individual Hired by the participant

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Supports for Participant Direction
Service Name: Independent Support Broker

Provider Category:

Agency

Provider Type:

CARF-accredited agency also certified by BHD for Independent Support Brokerage

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Any provider of this service is required to attain and maintain a certification for this service from the Wyoming Department of Health, Behavioral Health Division. BHD requires a provider to attain and maintain accreditation by the Commission on Accreditation of Rehabilitative Facilities (CARF) or other nationally recognized accreditation entity for human services as specified in Chapter 45 the Wyoming Medicaid rules.

Other Standard *(specify):*

Pursuant to Chapter 45, a support broker must have one year of experience in the field of ID/DD with a Bachelor's degree, Master's degree or Doctoral degree or two years (48 credit hours) of college and two years of experience. He/she must attend a Division training on Support Brokerage and pass a competency based test on Support Brokerage prior to providing the service.

An agency providing this service must meet the requirements in Wyoming Medicaid rules, Chapter 45, including assuring any employee providing this service successfully passes a Criminal History Background check, attains and maintains current CPR and First Aid Certification for all direct care staff, has employees certified in Medication Assistance for participants who need help with medications, has employees certified in crisis intervention and restraint usage(such as CPI or Mandt) if provider is serving participants with those possible needs, and has documentation on file that any employee in the agency transporting a participant has a current driver's license and automobile insurance. Agency direct care staff must also complete and document participant specific training before serving a participant, and complete and document general trainings on recognizing abuse and neglect, incident reporting, complaint process requirements, documentation standards, rights and rights restrictions, implementing the participant's objectives, and HIPAA & confidentiality requirements.
The Agency must adhere to the standards and requirements specified in Wyoming Medicaid Rules Chapter 45 and also meet all other the applicable Medicaid rules and regulations specified in the BHD Provider manual and provider agreement.

Verification of Provider Qualifications

Entity Responsible for Verification:

Behavioral Health Division

Frequency of Verification:

The Division initially certifies a CARF agency providing this service for one year and the agency is required to complete a recertification in all services provided every year thereafter. The Division has the authority to monitor agencies throughout their recertification period through the complaint process, incident reporting process, or internal referral process if there is indication the provider is not complying with the rules and regulations.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Supports for Participant Direction
Service Name: Independent Support Broker

Provider Category:

Agency

Provider Type:

Agency certified by BHD for Independent Support Brokerage

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Any provider of this service is required to attain and maintain a certification for this service from the Wyoming Department of Health, Behavioral Health Division.

Other Standard *(specify):*

Pursuant to Chapter 45, a support broker must have one year of experience in the field of ID/DD with a Bachelor's degree, Master's degree or Doctoral degree or two years (48 credit hours) of college and two years of experience. He/she must attend a Division training on Support Brokerage and pass a competency based test on Support Brokerage prior to providing the service.

An agency providing this service must meet the requirements in Wyoming Medicaid rules, Chapter 45, including assuring any employee providing this service successfully passes a Criminal History Background check, attains and maintains current CPR and First Aid Certification for all direct care staff, has employees certified in Medication Assistance for participants who need help with medications, has employees certified in crisis intervention and restraint usage(such as CPI or Mandt) if provider is serving participants with those possible needs, and has documentation on file that any employee in the agency transporting a participant has a current driver's license and automobile insurance. Agency direct care staff must also complete and document participant specific training before serving a participant, and complete and document general trainings on recognizing abuse and neglect, incident reporting, complaint process requirements, documentation standards, rights and rights restrictions, implementing the participant's objectives, and HIPAA & confidentiality requirements.
The Agency must adhere to the standards and requirements specified in Wyoming Medicaid Rules Chapter 45 and also meet all other the applicable Medicaid rules and regulations specified in the BHD Provider manual and provider agreement.

Verification of Provider Qualifications

Entity Responsible for Verification:

Behavioral Health Division

Frequency of Verification:

The Division initially certifies a new agency providing this service for one year and the agency is required to complete a recertification every year thereafter for the provision of this service. The Division has the authority to monitor agencies throughout their recertification period through the complaint process, incident reporting process, or internal referral process if there is indication the provider is not complying with the rules and regulations.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Supports for Participant Direction
Service Name: Independent Support Broker

Provider Category:

Individual

Provider Type:

Individual Hired by the participant

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Any provider of this service is required to attain and maintain a certification for this service from the Wyoming Department of Health, Behavioral Health Division.

Other Standard *(specify):*

Pursuant to Chapter 45, a support broker must have one year of experience in the field of ID/DD with a Bachelor's degree, Master's degree or Doctoral degree or two years (48 credit hours) of college and two years of experience. He/she must attend a Division training on Support Brokerage and pass a competency based test on Support Brokerage prior to providing the service.

The Fiscal/Employer Agent Financial Management Service verifies with documentation in a file that the individual being hired to provide this service:

- Is at least 18 years of age
- Has completed a successful criminal background check
- Has the ability to communicate effectively with the individual/family
- Has the ability to complete record keeping as required by the employer
- Has current CPR and First Aid Certification
- Has current Medication Assistance Training certification, if applicable
- Has Crisis Intervention and Restraint usage certification, such as CPI or Mandt, if applicable for participant's needs
- Has a current driver's license and automobile insurance if transporting the participant

The participant and/or legal representative, with assistance as needed from the Support Broker or case manager, verifies that, prior to working alone with the participant, the individual being hired demonstrates competence in knowledge of the following BHD policies and procedures:

- Recognizing abuse/neglect;
- Incident reporting;
- Participant rights and confidentiality;
- Emergency drills/situations;
- Documentation standards; and
- Demonstrates competence/knowledge in participants needs outlined in the individual plan of care

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Employer Agent- Financial Management Service

Frequency of Verification:

Employees hired through the Financial Management Service are required to attain, maintain, and show evidence of a successful Criminal History background, current CPR and First Aid certification, current driver's license and vehicle insurance (if transporting participants), and current certification in crisis intervention and restraint usage (if applicable for the participant's needs) prior to being employed and providing waiver services.

The Fiscal Employer Agent - FMS inputs all employee information into a database, which shows each item that an employee has completed in order to qualify to provide services to a participant. Any documentation that has an expiration date is entered into their database as to the date of when it expires and flags them to notify the employee and employer of record and support broker when an item is expiring.

Once an employee shows that all documentation is submitted, the Fiscal Employer Agent – FMS database is updated and the FMS allows the employee to start work.

Fiscal Employer Agent – FMS also does quarterly reviews on a random sample of files to ensure that all required documents are submitted and logged correctly in the database and file.

The Agent provides a weekly status report to support brokers regarding provider certifications, paperwork, status of trainings, and whether or not the provider has met all requirements to work for a participant. The Agent also provides a monthly report to support brokers, which includes a status of upcoming training expirations of providers. With assistance from the support broker, the participant will take on the responsibility and provide additional oversight in ensuring that all employees are current on all required certifications that have an expiration date such as CPR, First Aid, and Medication Assistance. If the employer of record wants to "opt out" of having a support broker, the Division ensures that the EOR understands their oversight responsibility in ensuring all providers are current in required certifications and how to work with the Agent to keep the employee file up-to-date.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Behavioral Support Services

HCBS Taxonomy:

Category 1:

10 Other Mental Health and Behavioral Services

Sub-Category 1:

10040 behavior support

Provider Category	Provider Type Title

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service

Definition *(Scope):*

Behavioral Support Service includes training, supervision, or assistance in appropriate expression of emotions and desires, compliance, assertiveness, acquisition of socially appropriate behaviors, and the reduction of inappropriate behaviors through the implementation of positive behavior support and interventions. Behavioral Support service can also be accessed for the intent purpose of reducing the use of restrictions and restraints within a participant's current plan of care or service environment.

Reimbursable activities:
- Observation of the individual and environment for purposes of development of a plan and to determine baseline
- Development of a behavioral support plan and subsequent revisions utilizing positive behavior supports and interventions.
- Obtain consensus of the Individualized Support Team that the behavioral support plan is feasible for implementation.
- Training in assertiveness
- Training in stress reduction techniques
- Training in the acquisition of socially accepted behaviors
- Training staff, family members, roommates, and other appropriate individuals on the implementation of the behavioral support plan
- Consultation with team members

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Behavioral Support services provided must not be covered under any billable service through the Medicaid State Plan and must be prior authorized by the Division.

Other activities that are not allowed under this service:
- Aversive techniques – Any aversive techniques not approved by the Division, the individual's person centered planning team, or the provider's human rights committee if applicable.
- Therapy services furnished to the participant within the educational/school setting or as a component of the participant's school day.
- Services furnished to a minor by a parent(s), step-parent(s), or legal guardian.
- Services furnished to a participant by the participant's spouse.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agency certified by BHD to provide Behavioral Support Services
Individual	Individual certified by BHD for Behavioral Support Services
Agency	Mental Health Agency certified to provide mental health therapy services

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Behavioral Support Services

Provider Category:
Agency

Provider Type:

Agency certified by BHD to provide Behavioral Support Services

Provider Qualifications

License *(specify):*

Any agency providing Behavioral Support Service must assure individuals providing the service have a current license to practice mental and behavioral therapy by either the Mental Health Professions Licensing Board or Board of Psychology per Wyoming Medicaid Rules, Chapter 45, and provide proof of specific training on positive behavior supports from an organization acceptable by the Behavioral Health Division.

Certificate *(specify):*

Any provider of this service is required to attain and maintain a certification for this service from the Wyoming Department of Health, Behavioral Health Division.

A qualified person may also be an individual with a Master's Degree and a Board Certified Behavior Analyst or have similar nationally recognized certification in positive behavior supports with approval from the Division.

Other Standard *(specify):*

Mental health agencies providing mental and behavioral health therapy services must ensure any staff providing the service successfully passes a Criminal History Background check, attains and maintains current CPR and First Aid Certification for all direct care staff, and has documentation on file that any employee in the agency transporting a participant has a current driver's license and automobile insurance. Agency direct care staff must also complete and document participant specific training before serving a participant, and complete and document general trainings on recognizing abuse and neglect, incident reporting, complaint process requirements, documentation standards, rights and rights restrictions, implementing the participant's objectives, and HIPAA & confidentiality requirements. The Agency must adhere to the standards and requirements specified in Wyoming Medicaid Rules Chapter 45 and also meet all other the applicable Medicaid rules and regulations specified in the BHD Provider manual and provider agreement.

Verification of Provider Qualifications

Entity Responsible for Verification:

Behavioral Health Division

Frequency of Verification:

BHD initially certifies an agency providing this service for one year and the agency is required to complete a recertification at the end of the first year. After the initial year certification, BHD may certify an agency in this service for up to three years. An agency, who receives a recommendation that identifies non-compliance with any rule and regulation pertaining to health, safety, rights or the standards for habilitation service provision may only receive up to a one-year recertification pending corrective action on the area of non-compliance. An agency, who does not receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation service standards may receive a three-year recertification. BHD has the authority to monitor agencies throughout their recertification period through the complaint process, incident reporting process, or internal referral process, if there is indication the agency is not complying with the rules and regulations.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Behavioral Support Services

Provider Category:

Individual

Provider Type:

Individual certified by BHD for Behavioral Support Services

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Any provider of this service is required to attain and maintain a certification for this service from the Wyoming Department of Health, Behavioral Health Division.

The individual must also have a Master's Degree and be a Board Certified Behavior Analyst or have similar nationally recognized certification in positive behavior supports with approval from the Division.

Other Standard *(specify):*

An individual provider providing behavioral support services must successfully passes a Criminal History Background check, attain and maintain current CPR and First Aid Certification, and if transporting a participant have a current driver's license and automobile insurance. He/She must also complete and document participant specific training before serving a participant, and complete and document general trainings on recognizing abuse and neglect, incident reporting, complaint process requirements, documentation standards, rights and rights restrictions, implementing the participant's objectives, and HIPAA & confidentiality requirements. The certified individual must adhere to the standards and requirements specified in Wyoming Medicaid Rules Chapter 45 and also meet all other the applicable Medicaid rules and regulations specified in the BHD Provider manual and provider agreement.

Verification of Provider Qualifications

Entity Responsible for Verification:

Behavioral Health Division

Frequency of Verification:

BHD initially certifies a provider providing this service for one year and the provider is required to complete a recertification at the end of the first year. After the initial year certification, BHD may certify a provider in this service for up to three years. An agency, who receives a recommendation that identifies non-compliance with any rule and regulation pertaining to health, safety, rights or the standards for habilitation service provision may only receive up to a one-year recertification pending corrective action on the area of non-compliance. An agency, who does not receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation service standards may receive a three-year recertification. BHD has the authority to monitor agencies throughout their recertification period through the complaint process, incident reporting process, or internal referral process, if there is indication the provider is not complying with the rules and regulations.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Behavioral Support Services

Provider Category:

Agency

Provider Type:

Mental Health Agency certified to provide mental health therapy services

Provider Qualifications

License *(specify):*

Medicaid certified or state licensed Mental Health Agency fully licensed in Wyoming.

Any agency providing Behavioral Support Service must assure individuals providing the service have a current license to practice mental and behavioral therapy by either the Mental Health Professions Licensing Board or Board of Psychology per Wyoming Medicaid Rules, Chapter 45, and provide proof of specific training on positive behavior supports from an organization acceptable by the Behavioral Health Division.

Certificate *(specify):*

Any provider of this service is required to attain and maintain a certification for this service from the Wyoming Department of Health, Behavioral Health Division.

A qualified person may also be an individual with a Master's Degree and a Board Certified Behavior Analyst or have similar nationally recognized certification in positive behavior supports with approval from the Division.

Other Standard *(specify):*

Mental health agencies providing mental and behavioral health therapy services must ensure any staff providing the service successfully passes a Criminal History Background check, attains and maintains current CPR and First Aid Certification for all direct care staff, and has documentation on file that any employee in the agency transporting a participant has a current driver's license and automobile insurance. Agency direct care staff must also complete and document participant specific training before serving a participant, and complete and document general trainings on recognizing abuse and neglect, incident reporting, complaint process requirements, documentation standards, rights and rights restrictions, implementing the participant's objectives, and HIPAA & confidentiality requirements. The Agency must adhere to the standards and requirements specified in Wyoming Medicaid Rules Chapter 45 and also meet all other the applicable Medicaid rules and regulations specified in the BHD Provider manual and provider agreement.

Verification of Provider Qualifications

Entity Responsible for Verification:

Behavioral Health Division

Frequency of Verification:

BHD initially certifies an agency providing this service for one year and the agency is required to complete a recertification at the end of the first year. After the initial year certification, BHD may certify an agency in this service for up to three years. An agency, who receives a recommendation that identifies non-compliance with any rule and regulation pertaining to health, safety, rights or the standards for habilitation service provision may only receive up to a one-year recertification pending corrective action on the area of non-compliance. An agency, who does not receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation service standards may receive a three-year recertification. BHD has the authority to monitor agencies throughout their recertification period through the complaint process, incident reporting process, or internal referral process, if there is indication the agency is not complying with the rules and regulations.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Provider Category	Provider Type Title

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Cognitive Retraining

HCBS Taxonomy:

Category 1:

13 Participant Training

Sub-Category 1:

13010 participant training

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service

Definition *(Scope):*

Training provided to the person served or family members that will assist the compensation or restoring cognitive function (e.g. ability/skills for learning, analysis, memory, attention, concentration, orientation, and information processing) in accordance with the Plan of Care (POC).

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agency certified by BHD to provide Cognitive Retraining

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Cognitive Retraining

Provider Category:

Agency

Provider Type:

Agency certified by BHD to provide Cognitive Retraining

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Any provider of this service is required to attain and maintain a certification for this service from the Wyoming Department of Health, Behavioral Health Division. BHD requires a provider to attain and maintain accreditation by the Commission on Accreditation of Rehabilitative Facilities (CARF) or other nationally recognized accreditation entity for human services as specified in Chapter 45 the Wyoming Medicaid rules. Agencies certified to provide cognitive retraining services are required to verify agency staff providing the services are certified in Cognitive Retraining from an accredited institution of higher learning, or be a certified Brain Injury Specialist through the Brain Injury Association of America, or be a licensed professional with one year of acquired brain injury training or Bachelors degree in related field and three years experience in acquired brain injuries.

Other Standard *(specify):*

An agency providing this service must meet the requirements in Wyoming Medicaid rules, Chapter 45, including assuring any employee providing this service successfully passes a Criminal History Background check, attains and maintains current CPR and First Aid Certification for all direct care staff, has employees certified in Medication Assistance for participants who need help with medications, has employees certified in crisis intervention and restraint usage(such as CPI or Mandt) if provider is serving participants with those possible needs, and has documentation on file that any employee in the agency transporting a participant has a current driver's license and automobile insurance. Agency direct care staff must also complete and document participant specific training before serving a participant, and complete and document general trainings on recognizing abuse and neglect, incident reporting, complaint process requirements, documentation standards, rights and rights restrictions, implementing the participant's objectives, and HIPAA & confidentiality requirements.

Verification of Provider Qualifications

Entity Responsible for Verification:

Behavioral Health Division

Frequency of Verification:

The Division initially certifies a CARF agency providing this service for one year and the agency may be recertified for up to two years or may be required to complete a recertification in all services provided every year. The Division has the authority to monitor agencies throughout their recertification period through the complaint process, incident reporting process, or internal referral process if there is indication the provider is not complying with the rules and regulations.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Companion Services

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
08 Home-Based Services	08040 companion
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service

Definition *(Scope):*

Provider Category: Provider Type Title:

Companion services include non-medical care, supervision, socialization and assisting a waiver participant in maintaining safety in the home and community and enhancing independence. Companions may assist or supervise the individual with such tasks as meal preparation, laundry, and shopping, but do not perform these activities as discrete services. Companions may also perform light housekeeping tasks that are incidental to the care and supervision of the participant. Companion services include informal training goals in areas specified in the individual plan of care. The provision of companion services does not entail hands-on nursing care, but does include personal care assistance with activities of daily living as needed during the provision of services.

Routine transportation is included in the reimbursement rate.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

This service is a 15-minute unit and is available as a 1:1 service or as a group rate serving up to 3 people. Service may be provided up to nine (9) hours a day unless the services are provided for a special event or an out of town trip. The rate does not change for special events or out of town trips. There are no limits other than the person's individual budget for special events or out of town trips.

There is an annual cap of 1664 if the person is in residential habilitation services and does not want to attend a day service program periodically but still requires supervision. This service may not be used in conjunction with residential habilitation, so service times may not overlap.

With the group rate, providers can provide companion services for two participants or three participants at the same time but must document at the rate for the specific group. Providers cannot serve children and adults at the same time unless authorized in advance by the Division.

Relative providers (excluding parents/stepparents) may provide this service.

Companion services cannot be provided during the same time period as other waiver services, which is subject to audit by the Program Integrity Unit within the Single State Medicaid Agency.

Service Delivery Method *(check each that applies)*:

- [x] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [ ] **Legally Responsible Person**
- [x] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	CARF-accredited agency also certified by BHD for Companion Services
Agency	Agency certified by BHD to provide Companion Services
Individual	Individual Hired by the participant

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Companion Services

Provider Category:

Agency

Provider Type:

CARF-accredited agency also certified by BHD for Companion Services

Provider Qualifications

License *(specify)*:

Certificate *(specify)*:

Any provider of this service is required to attain and maintain a certification for this service from the Wyoming Department of Health, Behavioral Health Division. BHD requires a provider to attain and maintain accreditation by the Commission on Accreditation of Rehabilitative Facilities (CARF) or other nationally recognized accreditation entity for human services as specified in Chapter 45 the Wyoming Medicaid rules.

Other Standard *(specify)*:

An agency providing this service must meet the requirements in Wyoming Medicaid rules, Chapter 45, including assuring any employee providing this service successfully passes a Criminal History Background check, attains and maintains current CPR and First Aid Certification for all direct care staff, has employees certified in Medication Assistance for participants who need help with medications, has employees certified in crisis intervention and restraint usage(such as CPI or Mandt) if provider is serving participants with those possible needs, and has documentation on file that any employee in the agency transporting a participant has a current driver's license and automobile insurance. Agency direct care staff must also complete and document participant specific training before serving a participant, and complete and document general trainings on recognizing abuse and neglect, incident reporting, complaint process requirements, documentation standards, rights and rights restrictions, implementing the participant's objectives, and HIPAA & confidentiality requirements.
The Agency must adhere to the standards and requirements specified in Wyoming Medicaid Rules Chapter 45 and also meet all other the applicable Medicaid rules and regulations specified in the BHD Provider manual and provider agreement.

Verification of Provider Qualifications

Entity Responsible for Verification:

Behavioral Health Division

Frequency of Verification:

The Division initially certifies a CARF agency providing this service for one year and the agency is required to complete a recertification in all services provided every year thereafter. The Division has the authority to monitor agencies throughout their recertification period through the complaint process, incident reporting process, or internal referral process if there is indication the provider is not complying with the rules and regulations.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Companion Services

Provider Category:

Agency

Provider Type:

Agency certified by BHD to provide Companion Services

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Any provider of this service is required to attain and maintain a certification for this service from the Wyoming Department of Health, Behavioral Health Division.

Other Standard *(specify):*

An agency providing this service must meet the requirements in Wyoming Medicaid rules, Chapter 45, including assuring any employee providing this service successfully passes a Criminal History Background check, attains and maintains current CPR and First Aid Certification for all direct care staff, has employees certified in Medication Assistance for participants who need help with medications, has employees certified in crisis intervention and restraint usage (such as CPI or Mandt) if provider is serving participants with those possible needs, and has documentation on file that any employee in the agency transporting a participant has a current driver's license and automobile insurance. Agency direct care staff must also complete and document participant specific training before serving a participant, and complete and document general trainings on recognizing abuse and neglect, incident reporting, complaint process requirements, documentation standards, rights and rights restrictions, implementing the participant's objectives, and HIPAA & confidentiality requirements.

The Agency must adhere to the standards and requirements specified in Wyoming Medicaid Rules Chapter 45 and also meet all other the applicable Medicaid rules and regulations specified in the BHD Provider manual and provider agreement.

Verification of Provider Qualifications

Entity Responsible for Verification:

Behavioral Health Division

Frequency of Verification:

BHD initially certifies an agency providing this service for one year and the agency is required to complete a recertification at the end of the first year. After the initial year certification, BHD may certify an agency in this service for up to two years. An agency, who receives a recommendation that identifies non-compliance with any rule and regulation pertaining to health, safety, rights or the standards for habilitation service provision may only receive up to a one-year recertification pending corrective action on the area of non-compliance. An agency, who does not receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation service standards may receive a two-year recertification. BHD has the authority to monitor agencies throughout their recertification period through the complaint process, incident reporting process, or internal referral process, if there is indication the agency is not complying with the rules and regulations.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Companion Services

Provider Category:
Individual

Provider Type:
Individual Hired by the participant

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

The Fiscal/Employer Agent Financial Management Service verifies with documentation in a file that the individual being hired to provide this service:

- Is at least 18 years of age
- Has completed a successful criminal background check
- Has the ability to communicate effectively with the individual/family
- Has the ability to complete record keeping as required by the employer
- Has current CPR and First Aid Certification
- Has current Medication Assistance Training certification, if applicable
- Has Crisis Intervention and Restraint usage certification, such as CPI or Mandt, if applicable for participant's needs
- Has a current driver's license and automobile insurance if transporting the participant

The participant and/or legal representative, with assistance as needed from the Support Broker or case manager, verifies that, prior to working alone with the participant, the individual being hired demonstrates competence in knowledge of the following BHD policies and procedures:

- Recognizing abuse/neglect;
- Incident reporting;
- Participant rights and confidentiality;
- Emergency drills/situations;
- Documentation standards; and
- Demonstrates competence/knowledge in participants needs outlined in the individual plan of care

Verification of Provider Qualifications

Entity Responsible for Verification:
Fiscal Employer Agent- Financial Management Service

Frequency of Verification:

Employees hired through the Financial Management Service are required to attain, maintain, and show evidence of a successful Criminal History background, current CPR and First Aid certification, current driver's license and vehicle insurance (if transporting participants), and current certification in crisis intervention and restraint usage (if applicable for the participant's needs) prior to being employed and providing waiver services.
The Fiscal Employer Agent - FMS inputs all employee information into a database, which shows each item that an employee has completed in order to qualify to provide services to a participant. Any documentation that has an expiration date is entered into their database as to the date of when it expires and flags them to notify the employee and employer of record and support broker when an item is expiring.
Once an employee shows that all documentation is submitted, the Fiscal Employer Agent – FMS database is updated and the FMS allows the employee to start work.

Fiscal Employer Agent – FMS also does quarterly reviews on a random sample of files to ensure that all required documents are submitted and logged correctly in the database and file.

The Agent provides a weekly status report to support brokers regarding provider certifications, paperwork, status of trainings, and whether or not the provider has met all requirements to work for a participant. The Agent also provides a monthly report to support brokers, which includes a status of upcoming training expirations of providers. The fiscal agent suspends all payments of a provider who lapses on their certification and notifies the provider and EOR.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Provider Category	Provider Type Title

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Crisis Intervention Support

HCBS Taxonomy:

Category 1:

10 Other Mental Health and Behavioral Services

Sub-Category 1:

10030 crisis intervention

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service

Category 4:

Sub-Category 4:

Definition *(Scope):*

Crisis Intervention support services may be added to a plan for situations where a participant's tier level may not provide sufficient support for specific activities, medical conditions or occurrences of behaviors or crisis, but the extensive supervision is not needed at all times. The service available to those who are eligible and have an assessed need for the service and must be used in conjunction with a habilitation service. Crisis Intervention provides funding for extra support from another staff to supervise a participant in the habilitation service during times of periodic behavioral episodes where the person is a danger to oneself or others, or if the participant has an occasional or temporary medically fragile situation and is at risk of imminent harm without the extra staff support. Intervention for behavioral purposes is not intended for watching the person should the behavior occur, but for the purpose of supporting the participant when the need arises, using positive behavior supports and non-violent, non-physical crisis intervention services to de-escalate a situation, teach appropriate behaviors and keep the participant safe until the participant is stable.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Quantity of caps approved by the Division's Clinical Review Team and shall be based on verified need, evidence of the diagnosis or condition requiring this service. Documentation of progress and data on behaviors and the outcome of the intervention services must be submitted to the case manager and Division at the frequency specified in the approved plan of care.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	CARF-accredited agency also certified by BHD for Crisis Intervention Support
Agency	Agency certified to provide Crisis Intervention Support

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Crisis Intervention Support

Provider Category:

Individual

Provider Type:

CARF-accredited agency also certified by BHD for Crisis Intervention Support

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Any provider of this service is required to attain and maintain a certification for this service from the Wyoming Department of Health, Behavioral Health Division. BHD requires a provider to attain and maintain accreditation by the Commission on Accreditation of Rehabilitative Facilities (CARF) or other nationally recognized accreditation entity for human services as specified in Chapter 45 the Wyoming Medicaid rules.

Other Standard *(specify):*

An agency providing this service must meet the requirements in Wyoming Medicaid rules, Chapter 45, including assuring any employee providing this service successfully passes a Criminal History Background check, attains and maintains current CPR and First Aid Certification for all direct care staff, has employees certified in Medication Assistance for participants who need help with medications, has employees certified in crisis intervention and restraint usage(such as CPI or Mandt) if provider is serving participants with those possible needs, and has documentation on file that any employee in the agency transporting a participant has a current driver's license and automobile insurance. Agency direct care staff must also complete and document participant specific training before serving a participant, and complete and document general trainings on recognizing abuse and neglect, incident reporting, complaint process requirements, documentation standards, rights and rights restrictions, implementing the participant's objectives, and HIPAA & confidentiality requirements.

The Agency must adhere to the standards and requirements specified in Wyoming Medicaid Rules Chapter 45 and also meet all other the applicable Medicaid rules and regulations specified in the BHD Provider manual and provider agreement.

For parent/stepparents provider agencies serving their adult child on the waiver, the agency shall become a certified Medicaid Waiver provider and an Limited Liability Company or a Corporation by the passage of House Enrolled Act 91 effective July 1, 2011. The parent or relative may not provide the service directly.

The Division initially certifies a CARF agency providing this service for one year and the agency is required to complete a recertification in all services provided every year thereafter. The Division has the authority to monitor agencies throughout their recertification period through the complaint process, incident reporting process, or internal referral process if there is indication the provider is not complying with the rules and regulations.

Verification of Provider Qualifications

Entity Responsible for Verification:

Behavioral Health Division

Frequency of Verification:

The Division initially certifies a CARF agency providing this service for one year and the agency is required to complete a recertification in all services provided every year thereafter. The Division has the authority to monitor agencies throughout their recertification period through the complaint process, incident reporting process, or internal referral process if there is indication the provider is not complying with the rules and regulations.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Crisis Intervention Support

Provider Category:

Agency

Provider Type:

Agency certified to provide Crisis Intervention Support

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Any provider of this service is required to attain and maintain a certification for this service from the Wyoming Department of Health, Behavioral Health Division.

Other Standard *(specify):*

An agency providing this service must meet the requirements in Wyoming Medicaid rules, Chapter 45, including assuring any employee providing this service successfully passes a Criminal History Background check, attains and maintains current CPR and First Aid Certification for all direct care staff, has employees certified in Medication Assistance for participants who need help with medications, has employees certified in crisis intervention and restraint usage(such as CPI or Mandt) if provider is serving participants with those possible needs, and has documentation on file that any employee in the agency transporting a participant has a current driver's license and automobile insurance. Agency direct care staff must also complete and document participant specific training before serving a participant, and complete and document general trainings on recognizing abuse and neglect, incident reporting, complaint process requirements, documentation standards, rights and rights restrictions, implementing the participant's objectives, and HIPAA & confidentiality requirements.

The Agency must adhere to the standards and requirements specified in Wyoming Medicaid Rules
Chapter 45 and also meet all other the applicable Medicaid rules and regulations specified in the BHD Provider manual and provider agreement.

For parent/stepparents provider agencies serving their child on the waiver, the agency shall become a certified Medicaid Waiver provider and an Limited Liability Company or a Corporation by the passage of House Enrolled Act 91 effective July 1, 2011. The Parent or relative may not provide the service directly.

Within one year of certification in this service, a CARF provider serving more than 5 participants with restraints or restrictive interventions in their plans are required to have a supervisor successfully complete the positive behavior support curriculum as developed by WIND at the University of Wyoming or another nationally recognized positive behavior support curriculum approved by the Division. An additional supervisor must be certified for every 10 additional participants with restraints or restrictive interventions in their plan.

(CPI or MANDT training is not enough to meet this requirement due to the need for a supervisor to have more understanding on the purpose of a functional behavior analysis, gathering data on antecedents and behaviors, analyzing data to see if treatment and PBS plans are effective, the effects of trauma when using restraints or restrictive interventions, the importance of developing relationships and rapport with participants to foster trust and self-awareness, and many other topics covered in these curriculums).

Verification of Provider Qualifications

Entity Responsible for Verification:

Behavioral Health Division

Frequency of Verification:

The Division initially certifies a new agency providing this service for one year and the agency is required to complete a recertification every year thereafter for the provision of this service. The Division has the authority to monitor agencies throughout their recertification period through the complaint process, incident reporting process, or internal referral process if there is indication the provider is not complying with the rules and regulations.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Dietician Services

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
11 Other Health and Therapeutic Services	11040 nutrition consultation
Category 2:	**Sub-Category 2:**
13 Participant Training	13010 participant training
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service

Provider Category	Provider Type Title

Definition *(Scope):*

Dietician Services provided by a registered dietician include menu planning, consultation with and training for caregivers, and education for the individual served. The service does not include the cost of meals. Dietician services are available on the Medicaid State plan so the waiver service is an extension of the Medicaid State plan. Dietician services may be used when the state plan services have been exhausted. Without this service, certain individuals would receive inadequate nourishment and would require institutionalization. The dietician services are those services designated in the participant's Individual Plan of Care and ordered by a physician.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

The clientele served by this service show a pattern of chronic and unusual need requiring dietician services. Chronic needs encompass conditions such as severe obesity, poor food choices that compromise health, special diets approved by a physician for specific diagnoses or severe allergies. Service is limited to services not provided under the Medicaid State Plan. Relative providers shall not provide this service. At least 30 minutes of service must be provided per session in order to bill.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agency certified by BHD to provide Dietician Services
Agency	Home Health Agency certified to provide Dietician Services

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Dietician Services

Provider Category:

Agency

Provider Type:

Agency certified by BHD to provide Dietician Services

Provider Qualifications

License *(specify):*

Agencies certified to provide dietician services are required to verify staff providing dietician services have a current license to practice as a dietician by the Commission on Dietetic Registration.

Certificate *(specify):*

Any provider of this service is required to attain and maintain a certification for this service from the Wyoming Department of Health, Behavioral Health Division.

Other Standard *(specify):*

An agency providing this service must meet the requirements in Wyoming Medicaid rules, Chapter 45, including assuring any employee providing this service successfully passes a Criminal History Background check, attains and maintains current CPR and First Aid Certification for all direct care staff, and has documentation on file that any employee in the agency transporting a participant has a current driver's license and automobile insurance. Agency direct care staff must also complete and document participant specific training before serving a participant, and complete and document general trainings on recognizing abuse and neglect, incident reporting, complaint process requirements, documentation standards, rights and rights restrictions, implementing the participant's objectives, and HIPAA & confidentiality requirements.

The Agency must adhere to the standards and requirements specified in Wyoming Medicaid Rules Chapter 45 and also meet all other the applicable Medicaid rules and regulations specified in the BHD Provider manual and provider agreement.

Verification of Provider Qualifications

Entity Responsible for Verification:

Behavioral Health Division

Frequency of Verification:

BHD initially certifies an agency providing this service for one year and the agency is required to complete a recertification at the end of the first year. After the initial year certification, BHD may certify an agency in this service for up to three years. An agency, who receives a recommendation that identifies non-compliance with any rule and regulation pertaining to health, safety, rights or the standards for habilitation service provision may only receive up to a one-year recertification pending corrective action on the area of non-compliance. An agency, who does not receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation service standards may receive a three-year recertification. BHD has the authority to monitor agencies throughout their recertification period through the complaint process, incident reporting process, or internal referral process, if there is indication the agency is not complying with the rules and regulations.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Dietician Services

Provider Category:

Agency

Provider Type:

Home Health Agency certified to provide Dietician Services

Provider Qualifications

License *(specify):*

Medicare certified or state licensed Home Health Agency fully licensed in Wyoming. Agencies certified to provide dietician services are required to verify staff providing dietician services have a current license to practice as a dietician by the Commission on Dietetic Registration.

Certificate *(specify):*

Agencies certified to provide dietician services are required to verify staff providing dietician services have a current license to practice as a dietician by the Commission on Dietetic Registration.

Any provider of this service is required to attain and maintain a certification for this service from the Wyoming Department of Health, Behavioral Health Division.

Other Standard *(specify):*

An agency providing this service must meet the requirements in Wyoming Medicaid rules, Chapter 45, including assuring any employee providing this service successfully passes a Criminal History Background check, attains and maintains current CPR and First Aid Certification for all direct care staff, and has documentation on file that any employee in the agency transporting a participant has a current driver's license and automobile insurance. Agency direct care staff must also complete and document participant specific training before serving a participant, and complete and document general trainings on recognizing abuse and neglect, incident reporting, complaint process requirements, documentation standards, rights and rights restrictions, implementing the participant's objectives, and HIPAA & confidentiality requirements.

The Agency must adhere to the standards and requirements specified in Wyoming Medicaid Rules Chapter 45 and also meet all other the applicable Medicaid rules and regulations specified in the BHD Provider manual and provider agreement.

Verification of Provider Qualifications

Entity Responsible for Verification:

Behavioral Health Division

Frequency of Verification:

BHD initially certifies an agency providing this service for one year and the agency is required to complete a recertification at the end of the first year. After the initial year certification, BHD may certify an agency in this service for up to three years. An agency, who receives a recommendation that identifies non-compliance with any rule and regulation pertaining to health, safety, rights or the standards for habilitation service provision may only receive up to a one-year recertification pending corrective action on the area of non-compliance. An agency, who does not receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation service standards may receive a three-year recertification. BHD has the authority to monitor agencies throughout their recertification period through the complaint process, incident reporting process, or internal referral process, if there is indication the agency is not complying with the rules and regulations.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Environmental Modifications

HCBS Taxonomy:

Category 1: 14 Equipment, Technology, and Modifications

Sub-Category 1: 14020 home and/or vehicle accessibility adaptations

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service

Category 4:

Sub-Category 4:

Definition *(Scope)*:

Environmental modifications include those functionally necessary physical adaptations to the private residence of the participant or the participant's family, required by the participant's service plan, that are necessary to ensure the health, welfare and safety of the participant or that enable the participant to function with greater independence in the home. Such adaptations include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or the installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies that are necessary for the welfare of the participant.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Lifetime cap of $20,000 per family, regardless of waiver. Cap begins for purchases made after July 1, 2013 on previous Wyoming Waivers. A critical health or safety service requests that exceeds the lifetime cap is subject to available funding and approval by ECC.

As stated in Wyoming Medicaid Rules, Chapter 44, Section 6: Environmental Modifications shall meet at least two of the following criteria for approval by the Division:
1. Be functionally necessary, and
2. Contribute to a person's ability to remain in or return to his or her home and out of an ICF/ID setting, or
3. Be necessary to ensure the person's health, welfare, and safety.

Adaptations that add to the total square footage of the home are excluded from this benefit except when necessary to complete an adaptation (e.g., in order to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair).
- Excluded are those adaptations or improvements to the home that are of general utility, and are not of direct medical or remedial benefit to the participant. Scope and Limitations of this service are found in Medicaid Rule Chapter 44.

Participants cannot have both Individual Goods and Services and Environmental Modifications on the plan.
- Any adaptations that are covered by Medicaid, a state independent living center, vocational rehabilitation are excluded.
- Home accessibility adaptations may not be furnished to adapt living arrangements that are owned or leased by providers of waiver services.

All services shall be provided in accordance with applicable State or local building codes.

The case manager will follow the process identified in Chapter 44, Section 7. The case manager should not obtain quotes until the overall scope of the project is approved by the Division.

The Division may schedule an on-site assessment of the environmental concern including an evaluation of functional necessity with appropriate professionals under contract with the Division. The Division may use a third party assess the proposed modification and need for the modification to ensure cost effectiveness.

Sale of environmental modifications must not profit the participant or family.

Case Manager shall not give copies of the individual plan of care to the environmental modification provider. The environmental modification provider shall receive a copy of the approved service authorization printout.

Relative providers (including parents/stepparents) may provide this service in accordance with Chapter 45, adhering to the following requirements:
- They are a certified Medicaid Waiver Environmental Modification Provider; and
- The Division receives at least one other bid from another provider to ensure cost effectiveness.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)*:

Provider Category	Provider Type Title

- [ ] **Legally Responsible Person**
- [x] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agency certified by BHD to provide Environmental Modifications

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Environmental Modifications

Provider Category:
Agency

Provider Type:
Agency certified by BHD to provide Environmental Modifications

Provider Qualifications

License *(specify):*
Any individual employed by an Agency certified to provide environmental modification services are required to assure he/she has the applicable building, electrical, plumbing contractor's license as required by local or state regulations.

Certificate *(specify):*
Any provider of this service is required to attain and maintain a certification for this service from the Wyoming Department of Health, Behavioral Health Division.

Other Standard *(specify):*
In addition to having the applicable building, electrical, plumbing contractor's license as required by local or state regulations, individuals certified to provide environmental modification services must also complete training on incident reporting, recertification, and HIPAA & Confidentiality.

The Agency must adhere to the standards and requirements specified in Wyoming Medicaid Rules Chapter 45 and also meet all other the applicable Medicaid rules and regulations specified in the BHD Provider manual and provider agreement.

Verification of Provider Qualifications

Entity Responsible for Verification:
Behavioral Health Division

Frequency of Verification:
BHD initially certifies an agency providing this service for one year and the agency is required to complete a recertification at the end of the first year. After the initial year certification, BHD may certify an agency in this service for up to three years. An agency, who receives a recommendation that identifies non-compliance with any rule and regulation pertaining to health, safety, or rights may only receive up to a one-year recertification pending corrective action on the area of non-compliance. An agency, who does not receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, or rights may receive a three-year recertification. BHD has the authority to monitor agencies throughout their recertification period through the complaint process, incident reporting process, or internal referral process, if there is indication the agency is not complying with the rules and regulations.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:
Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:
Self-Directed Goods and Services

HCBS Taxonomy:

Category 1: 14 Equipment, Technology, and Modifications

Sub-Category 1: 14032 supplies

Category 2: 14 Equipment, Technology, and Modifications

Sub-Category 2: 14031 equipment and technology

Category 3: 14 Equipment, Technology, and Modifications

Sub-Category 3: 14020 home and/or vehicle accessibility adaptations

Service

Category 4: 13 Participant Training

Sub-Category 4: 13010 participant training

Definition *(Scope):*

Goods and services are services, equipment, and supplies that provide direct benefit to the participant and support specific outcomes in the individual plan of care. The service, equipment or supply must:

1. Reduce the reliance of the participant on other paid supports, or
2. Be directly related to health or safety of the participant in the home or community, or
3. Be habilitative and contribute to a therapeutic objective, or
4. Increase the participant's ability to be integrated into the community, or
5. Provide resources to expand self-advocacy skills and knowledge.

Subject to approval by the Division, Goods and Services may include:

- Equipment not otherwise available through the specialized equipment waiver service
- Devices, aids, controls, supplies, or household appliances which enable individuals to increase the ability to perform activities of daily living or to perceive, control, or communicate with the environment and/or community in which s/he lives. Service includes items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid State Plan. Service includes vehicle modifications but does not include items of direct medical or remedial benefit to the individual. All items must meet applicable standards of manufacture, design, and installation.
- Transportation provided by family members (excluding parents, step-parents, guardians, or spouses per Wyoming State Statute), friends, and other licensed drivers for using non-agency vehicles to transport the person to services and activities specified in the person's individual plan of care unless the service includes transportation. The unit of service is one mile. The rate may not exceed the current state rate for mileage reimbursement and cannot include medical transportation covered by the Medicaid State Plan.
- Home modifications not otherwise allowed in the Environmental modification waiver service. Allowable modifications may include physical adaptations which are necessary to ensure the health, welfare, and safety of the individual in the home, enhance the individual's level of independence, or which enable the individual to function with greater independence in the home.
- Camps - May cover cost of the participant attending a camp, and in some cases, an attendant to accompany the person to a camp that he/she could not attend alone and additional staffing was not available at the camp to ensure the person's health and safety.
- Consultation, evaluation and training, and/or a written document that evaluates and identifies the participant's strengths, needs, current availability and potential capacity of natural supports, and the need for service and financial resources, if appropriate. As appropriate for the participant, a consultation shall include participant preferences, health status, medications, conditions and treatments, functional performance, including Activities of Daily Living (ADLs), level of assistance needed, and assistive devices used and/or needed. Behavior and emotional factors, including pertinent history, coping mechanisms, and stressors. Cognitive functioning, including memory, attention, judgment, and general cognitive measures. Environmental factors, including architectural, transportation, other barriers. Social supports and networks, including natural supports. Financial factors, including guardianship or conservatorships, or entitlements that influence the array of supports and services that are needed.

Consultations and evaluations may be warranted based upon a specific disability, diagnosis, behavior concern, or medical condition relating to the disability. Family members and the person's environment may be involved in the consultation and training, which will help the person increase their health and safety, minimize the use of paid supports, and reduce the likelihood of institutionalization. This consultation and evaluation shall be used by the family and participant's team to better provide both paid and unpaid supports for the participant.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Self-Directed Goods and Services Provider Type: $2,000 annual limit and typically include any device which is not currently allowed under Specialized Equipment. All goods and services must be prior authorized by the Division and cannot be available through Specialized Equipment or Environmental Modifications on the waiver as specified in Chapter 44 of the Medicaid Rules. The Division may approve requests above the limit if the request meets the specified criteria.

Criteria for approving requests above the limit shall include goods or service needs that are due to:
- Unmet needs because of aging out of school
- Documented unavailability of vocational rehabilitation services
- Increasing health concerns that require more services
- Increasing behavioral concerns that require more intervention
- Health needs of unpaid caregivers who cannot continue the historical level of support.

Equipment purchases have a cap of $2,000 and cannot include any item covered under the specialized equipment waiver service. If an item needed exceeds that amount, the team may request an exception to the cap through the ECC. The Division may require an assessment for an equipment purchase by a Certified Specialized Equipment (CSE) professional. Assessment is funded as a part of the $2,000 cap.

Electronic technology devices are only allowed once every five (5) years and like items cannot be purchased during those five (5) years. There are no exceptions. The Division shall limit the purchase of any general item purchase and only allow the purchase of an iPad or other electronic devices, if recommended by CSE professional.

Certain items may not covered, such computers, bikes, or furniture, if the item does not meet the criteria of the service definition. A list is not included because each situation is different depending on the person's diagnosis, condition, and assessed needs.

Goods and Services approved by the Division only cover the costs for the actual device. It does not include any insurance. If the person wants insurance, he/she must purchase it on separately.

This service is only available for participants self-directing at least one direct care service through the Fiscal Employer Agent FMS option. This service may be provided by a relative (excluding parents/stepparents). This service may not duplicate any Medicaid State Plan service.

Modifications to a residence, that are not covered under the environmental modification service, may be approved if the cost of such modifications does not exceed the value of the residence before the modification. Covered modifications of rented or leased homes shall be those extraordinary alterations that are uniquely needed by the individual and for which the property owner would not ordinarily be responsible. Service does not include adaptations or improvements to the home, which are of general utility and are not of direct medical or remedial benefit, nor adaptations that add to the total square footage of the home or are covered as an environmental modification.

All Goods and Services, Specialized Equipment and Environmental Modifications are prior authorized by the Division. Items are tracked in the electronic plan of care system, EMWS. Preapproved by the BHD specialists. All documentation of these items are kept within the EMWS from one plan year to the next, so all BHD specialists may review why has been requested before.

Service Delivery Method *(check each that applies)*:

- [x] **Participant-directed as specified in Appendix E**
- [ ] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Commercial/Retail Business
Individual	Individual Hired by the participant

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Self-Directed Goods and Services

Provider Category:
Agency

Provider Type:
Commercial/Retail Business

Provider Qualifications

License *(specify)*:
Applicable state/local business license

Certificate *(specify)*:

Other Standard *(specify):*

Meets applicable state and local requirements for type of item that the vendor is providing.

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Employer Agent-Financial Management Service

Frequency of Verification:

Prior to employment or prior to processing invoice - Fiscal Employer Agent - Financial Management Service shall verify the provider qualifications for the good or service being purchased.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Self-Directed Goods and Services

Provider Category:

Individual

Provider Type:

Individual Hired by the participant

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

The Fiscal/Employer Agent Financial Management Service verifies with documentation in a file that the individual being hired to provide this service:

- Is at least 18 years of age
- Has completed a successful criminal background check
- Has the ability to communicate effectively with the individual/family
- Has the ability to complete record keeping as required by the employer
- Has current CPR and First Aid Certification
- Has a current driver's license and automobile insurance if transporting the participant

The participant and/or legal representative, with assistance as needed from the Support Broker or case manager, verifies that, prior to working alone with the participant, the individual being hired demonstrates competence in knowledge of the following BHD policies and procedures:

- Recognizing abuse/neglect;
- Incident reporting;
- Participant rights and confidentiality;
- Emergency drills/situations;
- Documentation standards; and
- Demonstrates competence/knowledge in participants needs outlined in the individual plan of care

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Employer Agent- Financial Management Service

Frequency of Verification:

Employees hired through the Financial Management Service are required to attain, maintain, and show evidence of a successful Criminal History background, current CPR and First Aid certification, current driver's license and vehicle insurance (if transporting participants), and current certification in crisis intervention and restraint usage (if applicable for the participant's needs) prior to being employed and providing waiver services.
The Fiscal Employer Agent - FMS inputs all employee information into a database, which shows each item that an employee has completed in order to qualify to provide services to a participant. Any documentation that has an expiration date is entered into their database as to the date of when it expires and flags them to notify the employee and employer of record and support broker when an item is expiring.
Once an employee shows that all documentation is submitted, the Fiscal Employer Agent – FMS database is updated and the FMS allows the employee to start work.

Fiscal Employer Agent – FMS also does quarterly reviews on a random sample of files to ensure that all required documents are submitted and logged correctly in the database and file.
The Agent provides a weekly status report to support brokers regarding provider certifications, paperwork, status of trainings, and whether or not the provider has met all requirements to work for a participant. The Agent also provides a monthly report to support brokers, which includes a status of upcoming training expirations of providers. With assistance from the support broker, the participant will take on the responsibility and provide additional oversight in ensuring that all employees are current on all required certifications that have an expiration date such as CPR, First Aid, and Medication Assistance. If the employer of record wants to "opt out" of having a support broker, the Division ensures that the EOR understands their oversight responsibility in ensuring all providers are current in required certifications and how to work with the Agent to keep the employee file up-to-date.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Skilled Nursing

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Service

Category 4: **Sub-Category 4:**

Definition *(Scope):*

Skilled Nursing services are medical care services delivered to individuals with complex chronic and/or acute medical conditions, which is performed within the Nurses' scope of practice as defined by Wyoming's Nurse Practice Act, which includes the application of the nursing process including assessment, diagnosis, planning, intervention and evaluation and the administration, teaching, counseling, supervision, delegation, and evaluation of nursing practice and the execution of the medical regimen. The services must require a level of expertise that is undeliverable by non-medical trained individuals. The delivery of Skilled Nursing services is limited to those individuals who possess a valid and unencumbered license issued by the Wyoming State Board of Nursing.

Skilled Nursing services are available on the Medicaid State plan by home health providers, therefore the waiver service is an extension of the Medicaid State plan. Skilled Nursing services may be used when the state plan services have been exhausted, are not available in the person's area, not available due to services denied by the home health provider, or the hours of need for the service are not available by the home health provider. Services approved in the plan of care that must be within the scope of the State's Nurse Practice Act.

- Skilled nursing may not be used if trained provider staff are able to provide the service, such as medication assistance or support for a medical appointment, unless the participant has a chronic or acute medical condition that requires a skilled nurse's direct support.
- Skilled nursing on the waiver may be provided by provider agencies and independent nurses as long as they meet the provider qualifications. The Wyoming Medicaid State Plan requires that skilled nursing services be provided by home health agencies that provide a minimum of two medically necessary services.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

A billable unit of nursing service unit is provided 15 minutes and that involves one-on-one direct patient care.
• Providers cannot be reimbursed for skilled nursing services that do not include direct patient care or services that do not include skilled nursing duties. For example, skilled nursing providers cannot be reimbursed for watching television with a participant, transportation to and from doctor appointments, time spent charting, time spent in waiting room with participant, or time spent completing paperwork.
• Skilled Nursing services are available on the waiver if a person cannot get the services through home health on the Medicaid State Plan, which requires that skilled nursing services be provided if a minimum of two (2) medically necessary services are needed.
* Relative providers shall not provide this service.

Service Delivery Method *(check each that applies)*:

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)*:

- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Home Health Agency certified to provide Skilled Nursing
Agency	Agency certified by BHD to provide Skilled Nursing

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Skilled Nursing

Provider Category:
Agency

Provider Type:
Home Health Agency certified to provide Skilled Nursing

Provider Qualifications

License *(specify)*:
Medicare certified or state licensed Home Health Agency fully licensed in Wyoming.

Agencies certified to provide skilled nursing services are required to verify that any individual providing skilled nursing services has a current license to practice nursing by the Wyoming State Board of Nursing per Wyoming Medicaid Rules, Chapter 45. Individuals providing skilled nursing services must be a registered professional nurse, or licensed practical or vocational nurse under the supervision of a registered nurse, licensed to practice in the State.

Certificate *(specify)*:
Any provider of this service is required to attain and maintain a certification for this service from the Wyoming Department of Health, Behavioral Health Division.

Other Standard *(specify)*:
An agency providing this service must meet the requirements in Wyoming Medicaid rules, Chapter 45, including assuring any employee providing this service successfully passes a Criminal History Background check, attains and maintains current CPR and First Aid Certification for all direct care staff, and has documentation on file that any employee in the agency transporting a participant has a current driver's license and automobile insurance. Agency direct care staff must also complete and document participant specific training before serving a participant, and complete and document general trainings on recognizing abuse and neglect, incident reporting, complaint process requirements, documentation standards, rights and rights restrictions, implementing the participant's objectives, and HIPAA & confidentiality requirements.
The Agency must adhere to the standards and requirements specified in Wyoming Medicaid Rules Chapter 45 and also meet all other the applicable Medicaid rules and regulations specified in the BHD Provider manual and provider agreement.

Verification of Provider Qualifications

Entity Responsible for Verification:
Behavioral Health Division

Frequency of Verification:

BHD initially certifies an agency providing this service for one year and the agency is required to complete a recertification at the end of the first year. After the initial year certification, BHD may certify an agency in this service for up to three years. An agency, who receives a recommendation that identifies non-compliance with any rule and regulation pertaining to health, safety, rights or the standards for habilitation service provision may only receive up to a one-year recertification pending corrective action on the area of non-compliance. An agency, who does not receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation service standards may receive a three-year recertification. BHD has the authority to monitor agencies throughout their recertification period through the complaint process, incident reporting process, or internal referral process, if there is indication the agency is not complying with the rules and regulations.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Skilled Nursing

Provider Category:

Agency

Provider Type:

Agency certified by BHD to provide Skilled Nursing

Provider Qualifications

License *(specify):*

Any individual providing skilled nursing services must have a current license to practice nursing by the Wyoming State Board of Nursing per Wyoming Medicaid Rules, Chapter 45. Individuals providing skilled nursing services must be a registered professional nurse, or licensed practical or vocational nurse under the supervision of a registered nurse, licensed to practice in the State.

Certificate *(specify):*

Any provider of this service is required to attain and maintain a certification for this service from the Wyoming Department of Health, Behavioral Health Division.

Other Standard *(specify):*

An agency providing this service must meet the requirements in Wyoming Medicaid rules, Chapter 45, including assuring any employee providing this service successfully passes a Criminal History Background check, attains and maintains current CPR and First Aid Certification for all direct care staff, and has documentation on file that any employee in the agency transporting a participant has a current driver's license and automobile insurance. Agency direct care staff must also complete and document participant specific training before serving a participant, and complete and document general trainings on recognizing abuse and neglect, incident reporting, complaint process requirements, documentation standards, rights and rights restrictions, implementing the participant's objectives, and HIPAA & confidentiality requirements.
The Agency must adhere to the standards and requirements specified in Wyoming Medicaid Rules Chapter 45 and also meet all other the applicable Medicaid rules and regulations specified in the BHD Provider manual and provider agreement.

Verification of Provider Qualifications

Entity Responsible for Verification:

Behavioral Health Division

Frequency of Verification:

BHD initially certifies an agency providing this service for one year and the agency is required to complete a recertification at the end of the first year. After the initial year certification, BHD may certify an agency in this service for up to three years. An agency, who receives a recommendation that identifies non-compliance with any rule and regulation pertaining to health, safety, rights or the standards for habilitation service provision may only receive up to a one-year recertification pending corrective action on the area of non-compliance. An agency, who does not receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation service standards may receive a three-year recertification. BHD has the authority to monitor agencies throughout their recertification period through the complaint process, incident reporting process, or internal referral process, if there is indication the agency is not complying with the rules and regulations.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Specialized Equipment

HCBS Taxonomy:

Category 1: 14 Equipment, Technology, and Modifications

Sub-Category 1: 14010 personal emergency response system (PERS)

Category 2: 14 Equipment, Technology, and Modifications

Sub-Category 2: 14020 home and/or vehicle accessibility adaptations

Category 3: 14 Equipment, Technology, and Modifications

Sub-Category 3: 14031 equipment and technology

Category 4: 14 Equipment, Technology, and Modifications

Sub-Category 4: 14032 supplies

Service

Definition *(Scope)*:

Specialized equipment includes:
1. Devices, controls, or appliances, specified in the plan of care, that enable participants to increase their ability to perform activities of daily living;
2. Devices, controls, or appliances that enable the participant to perceive, control, or communicate with the environment in which they live;
3. Items necessary for life support or to address physical conditions along with ancillary supplies and equipment necessary to the proper functioning of such items;
4. Such other durable and non-durable medical equipment not available under the Medicaid state plan that is necessary to address participant functional limitations; and,
5. Necessary medical supplies not available under the Medicaid state plan or other insurance held by the participant. Items reimbursed with waiver funds are in addition to any medical equipment and supplies furnished under the state plan and exclude those items that are not of direct medical or remedial benefit to the participant. All items shall meet applicable standards of manufacture, design and installation.

If the participant has an IEP or IFSP, the case manager will be required to submit a copy of that document, along with documentation as to why the equipment is not sent home with the participant or a reason why the equipment is necessary at home but not at school.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Specialized equipment shall meet at least three of the following criteria and is subject to BHD approval:
1. Be functionally necessary, and
2. Be necessary to increase ability to perform activities of daily living or to perceive control, or communicate with the environment in which the person lives, or
3. Be necessary to enable the participant to function with greater independence and without which the person would require institutionalization, or
4. Be necessary to ensure the person's health, welfare, and safety.

Allowable items and limitations of this service are found in Medicaid Rule Chapter 44.

Relative providers (including parents/stepparents) may provide this service with the following requirements:
- They are a certified Medicaid Waiver Specialized Equipment Provider; and
- Do not impose a mark-up to the total cost of the equipment when providing this service to their relative (unless they operate a non-profit corporation); and
- Receive at least one other bid from another provider to ensure cost effectiveness.

The individualized plan of care shall reflect the need for equipment, how the equipment addresses health, safety, or accessibility needs of the participant or allows them to function with greater independence, and specific information on how often the equipment is used and where it is used. Criteria for approval is outlined in Chapter 44 of the Wyoming Medicaid Rules. The case manager shall check with Medicaid, Medicare, and/or a participant's other insurance carrier to see if the requested equipment is covered under their plans. Waiver funds are a payer of last resort. The Medicaid waivers can only pay for what is functionally necessary, in other words, no convenience items.

Service Caps
Equipment purchases have an annual cap of $2,000. If an item needed exceeds that amount, the team may request an exception to the cap through the ECC. The Division may require an assessment for specialized equipment needs by a Certified Specialized Equipment (CSE) professional. Assessment is funded as a part of the $2,000 cap.

Electronic technology devices are only allowed once every five (5) years and like items cannot be purchased during those five (5) years.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)*:

- ☐ **Legally Responsible Person**

Provider Category	Provider Type Title

Relative
Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agency certified by BHD to provide Specialized Equipment

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Specialized Equipment

Provider Category:
Agency

Provider Type:
Agency certified by BHD to provide Specialized Equipment

Provider Qualifications

License *(specify):*
Any applicable license for the type of equipment purchased for a participant.

Certificate *(specify):*
Any applicable certification for the type of equipment purchased for a participant.

Other Standard *(specify):*
An agency providing this service must meet the requirements in Wyoming Medicaid rules, Chapter 45, including assuring any employee providing this service successfully passes a Criminal History Background check, complete training on incident reporting and HIPAA & confidentiality requirements.
The Agency must adhere to the standards and requirements specified in Wyoming Medicaid Rules Chapter 45 and also meet all other the applicable Medicaid rules and regulations specified in the BHD Provider manual and provider agreement.

Verification of Provider Qualifications

Entity Responsible for Verification:
Behavioral Health Division

Frequency of Verification:
BHD initially certifies an agency providing this service for one year and the agency is required to complete a recertification at the end of the first year. After the initial year certification, BHD may certify an agency in this service for up to three years. An agency, who receives a recommendation that identifies non-compliance with any rule and regulation pertaining to health, safety, rights or the standards for habilitation service provision may only receive up to a one-year recertification pending corrective action on the area of non-compliance. An agency, who does not receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation service standards may receive a three-year recertification. BHD has the authority to monitor agencies throughout their recertification period through the complaint process, incident reporting process, or internal referral process, if there is indication the agency is not complying with the rules and regulations.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:
Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:
Transportation

HCBS Taxonomy:

Provider Category	Provider Type Title

Category 1:

15 Non-Medical Transportation

Sub-Category 1:

15010 non-medical transportation

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service

Category 4:

Sub-Category 4:

Definition *(Scope):*

Transportation service on the waiver is a gap service to enable participants to gain access to an employment location, community services, activities, and resources as specified by the plan of care when a service provider is not needed at the event. Service is not intended to replace formal or informal transportation options, like the use of natural supports, city transportation services, and travel vouchers. Transportation services under the waiver shall be offered in accordance with an individual's plan of care and whenever possible, family, neighbors, friends, or community agencies which can provide this service without charge or with other resources will be utilized.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

This service does not include transportation to medical appointments required under 42 CFR 431.53 and transportation services available under the Medicaid state plan.

Service will be reimbursed based on mileage used. Service is capped at $2,000 per year.

Transportation must be provided by certified waiver providers who are certified for this service.

Transportation services cannot be utilized in conjunction with or to access other waiver services that specify in the service scope that transportation is covered in the rate for that service.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	CARF-accredited agency also certified by BHD for Transportation Services
Agency	Agency certified by BHD to provide Transportation services

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Transportation

Provider Category:

Agency

Provider Type:

CARF-accredited agency also certified by BHD for Transportation Services

Provider Qualifications

License *(specify):*

The certified provider agency or employee of a certified provider transporting an individual must have a current, valid Wyoming driver's license.

Certificate *(specify):*

Any provider of this service is required to attain and maintain a certification for this service from the Wyoming Department of Health, Behavioral Health Division. BHD requires a provider to attain and maintain accreditation by the Commission on Accreditation of Rehabilitative Facilities (CARF) or other nationally recognized accreditation entity for human services as specified in Chapter 45 the Wyoming Medicaid rules.

Other Standard *(specify):*

An agency providing this service must meet the requirements in Wyoming Medicaid rules, Chapter 45, including assuring any employee providing this service successfully passes a Criminal History Background check, attains and maintains current CPR and First Aid Certification for all direct care staff and has documentation on file that any employee in the agency transporting a participant has a current driver's license, automobile insurance, and the provider has the additional liability insurance for transporting people for business purposes according to state requirements. Agency staff must also complete and document general trainings on recognizing abuse and neglect, incident reporting, complaint process requirements, documentation standards, participant rights and rights restrictions, implementing the participant's objectives, and HIPAA & confidentiality requirements.

The Agency must adhere to the standards and requirements specified in Wyoming Medicaid Rules Chapter 45 and also meet all other the applicable Medicaid rules and regulations specified in the BHD Provider manual and provider agreement.

Verification of Provider Qualifications

Entity Responsible for Verification:

Behavioral Health Division

Frequency of Verification:

The Division initially certifies a CARF agency providing this service for one year and the agency is required to complete a recertification in all services provided every year thereafter. The Division has the authority to monitor agencies throughout their recertification period through the complaint process, incident reporting process, or internal referral process if there is indication the provider is not complying with the rules and regulations.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Transportation

Provider Category:

Agency

Provider Type:

Agency certified by BHD to provide Transportation services

Provider Qualifications

License *(specify):*

The certified provider agency or employee of a certified provider transporting an individual must have a current, valid Wyoming driver's license.

Certificate *(specify):*

Any provider of this service is required to attain and maintain a certification for this service from the Wyoming Department of Health, Behavioral Health Division.

Other Standard *(specify):*

An agency providing this service must meet the requirements in Wyoming Medicaid rules, Chapter 45, including assuring any employee providing this service successfully passes a Criminal History Background check, attains and maintains current CPR and First Aid Certification for all direct care staff and has documentation on file that any employee in the agency transporting a participant has a current driver's license, automobile insurance, and the provider has the additional liability insurance for transporting people for business purposes according to state requirements. Agency staff must also complete and document general trainings on recognizing abuse and neglect, incident reporting, complaint process requirements, documentation standards, participant rights and rights restrictions, implementing the participant's objectives, and HIPAA & confidentiality requirements.

The Agency must adhere to the standards and requirements specified in Wyoming Medicaid Rules Chapter 45 and also meet all other the applicable Medicaid rules and regulations specified in the BHD Provider manual and provider agreement.

Verification of Provider Qualifications

Entity Responsible for Verification:

Behavioral Health Division

Frequency of Verification:

The Division initially certifies an agency providing this service for one year and the agency is required to complete a recertification in all services provided every year thereafter. The Division has the authority to monitor agencies throughout their recertification period through the complaint process, incident reporting process, or internal referral process if there is indication the provider is not complying with the rules and

Appendix C: Participant Services

C-1: Summary of Services Covered (2 of 2)

b. Provision of Case Management Services to Waiver Participants. Indicate how case management is furnished to waiver participants (*select one*):

- **Not applicable** - Case management is not furnished as a distinct activity to waiver participants.
- **Applicable** - Case management is furnished as a distinct activity to waiver participants.

Check each that applies:

- **As a waiver service defined in Appendix C-3.** *Do not complete item C-1-c.*
- **As a Medicaid State plan service under §1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*
- **As a Medicaid State plan service under §1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*
- **As an administrative activity.** *Complete item C-1-c.*

c. Delivery of Case Management Services. Specify the entity or entities that conduct case management functions on behalf of waiver participants:

Case managers are not employed by the state. They are either employed by a Medicaid Waiver provider organization certified to provide case management services, or independently certified as a Medicaid Waiver provider agency to provide case management services. Case managers are responsible for developing and submitting a service plan for a participant once a year. The case manager must coordinate at least two team meetings a year related to a participant's service plan, once to develop the annual plan of care, and a semi annual review meeting. Case managers must make a monthly home visit to the participant's residence, provide ongoing monitoring of the implementation of the plan of care, and ensure issues are addressed regarding any concerns with a participant's health and welfare.

Appendix C: Participant Services

C-2: General Service Specifications (1 of 3)

a. Criminal History and/or Background Investigations. Specify the State's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services (select one):

- **No. Criminal history and/or background investigations are not required.**
- **Yes. Criminal history and/or background investigations are required.**

Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

BHD oversees the provider background check process and requires all employees of waiver providers and direct service workers chosen by self-directing participants to complete a Federal Bureau of Investigation (FBI) fingerprint background check and State of Wyoming Division of
Criminal Investigation (DCI) fingerprint background check per Wyoming Medicaid rules, Chapter 45. The only exceptions are waiver providers certified to provide environmental modifications, specialized equipment, or services funded through Goods and Services that are not direct services. These service providers or staff are not required to complete a background check since they are not providing direct services.

Any time a provider chooses to add a direct service to their provider certification, BHD requires the provider to complete a background screening before the provider is approved to provide the service. Anytime a participant or their representative self-directing a service chooses to hire a new worker, the Financial Management Service must assure the background check process is completed before the worker can receive reimbursement for working for the participant. The background check must verify the provider, provider staff, or worker employed by a self-directing participant has not been convicted of any felony, or any misdemeanor that is an Offense Against the Person or an Offense Against Morals, Decency and Family, including:
Homicide (W.S. § 6-2-101 et seq.)
Kidnapping (W.S. § 6-2-201 et seq.)
Sexual assault (W.S. § 6-2-301 et seq.)
Robbery and blackmail (W.S. § 6-2-401 et seq.),
Assault and battery (W.S. § 6-2-501 et seq.),
Bigamy (W.S. § 6-4-401)
Incest (W.S. § 6-4-402)
Abandoning or endangering children (W.S. § 6-4-403)
Violation of order of protection (W.S. § 6-4-404), and
Endangering children; controlled substances (W.S. § 6-4-405), or
Similar laws of any other state or the United States relating to these crimes.

BHD requires provider applicants to complete a background check before they are certified to provide services. To assure the background check is completed BHD submits the background check paperwork to the Wyoming Division of Criminal Investigation and receives the results of the background check verifying the provider applicant has no convictions which disqualify him/her to provide waiver services. The
results are maintained in the provider file. Provider agency staff are required to submit to the background check upon hire and keep verification of the results of the background check in the individual staff's personnel file. BHD completes a staff file review of provider agencies during the provider recertification process to assure background checks have been completed and to verify that staff meet the background check requirements to provide waiver services. BHD also oversees the Financial Management Service provider to assure background checks are completed before workers hired by the participant begin working with the participant.

b. Abuse Registry Screening. Specify whether the State requires the screening of individuals who provide waiver services through a State-maintained abuse registry (select one):

Waiver Service	Provided in Facility	Facility Type	

No. The State does not conduct abuse registry screening.

Yes. The State maintains an abuse registry and requires the screening of individuals through this registry.

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

The Wyoming Department of Family Services (DFS) maintains the Central Registry of child and disabled adult protection cases, as authorized in Wyoming State Statute W.S. §7-19-201. Wyoming statute delegates the Department of Family Services as the authority for maintaining the Central Registry. The registry contains the list of all individuals who have been substantiated against for abuse, neglect, exploitation, abandonment or intimidation of vulnerable adults and children. All providers are required to submit fingerprints and a Central Registry disclosure form to DCI who completes a full screening to ensure the provider is not listed on the DFS central registry or on the FBI criminal database for criminal offense that would exclude them in being a provider.

Appendix C: Participant Services

C-2: General Service Specifications (2 of 3)

c. Services in Facilities Subject to §1616(e) of the Social Security Act. *Select one:*

No. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act.

Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

i. Types of Facilities Subject to §1616(e). Complete the following table for each type of facility subject to §1616(e) of the Act:

Facility Type	
Community-Based Group Home	

ii. Larger Facilities: In the case of residential facilities subject to §1616(e) that serve four or more individuals unrelated to the proprietor, describe how a home and community character is maintained in these settings.

The standards for a residential facility certified by the Behavioral Health Division detailed in Wyoming Medicaid Rules, Chapter 45.

Each residential facility where a participant lives is considered to be the participant's home. Individuals may decorate their personal space however they wish, and for common areas shared by more than one individual, input from each person is sought, and consideration is given to each person's needs, preferences, likes, and dislikes. Each facility must have home and community character, which means it is community-based, provides an environment that is like a home, provides full access to typical facilities in a home such as a kitchen with cooking facilities, small dining areas, provides for privacy and easy access to resources, stores, scheduled and unscheduled activities in the community. The residential facilities should be located in residential neighborhoods and have agency transportation or easy access to public transportation to visit friends, and participate in integrated and inclusive activities in their communities. Participants in the facility have the opportunity for visitors at times of preference and convenience to them. Waiver services may not be provided in institution-like settings.

The Behavioral Health Division shall no longer certify any new residential facilities to serve more than four individuals in a residential setting. Some exceptions to this policy are granted for facilities providing waiver services on a waiver administered by BHD prior to July 2013. Exceptions include facilities that had received HUD funding prior to waiver enrollment (with a specified number of household members) and were later converted to receive waiver services.

Any and all exceptions require the approval of the BHD Administrator. All homes that meet the exception must meet the standards for home and community character. All exceptions to the existing policy are based on justifications such as assuring privacy, community integration and individual participation as specified in Wyoming Medicaid Rules, Chapter 45. No exceptions are made for facilities that began to provide waiver services August 2013 or later.

Certified Waiver Providers must have each facility inspected annually by BHD, including any subcontract homes providing residential habilitation.

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Community-Based Group Home

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Speech, Hearing and Language Services	☐
Prevocational Services	☐
Crisis Intervention Support	☐

Waiver Service	Provided in Facility
Personal Care	☐
Cognitive Retraining	☐
Companion Services	☐
Independent Support Broker	☐
Residential Habilitation	☑
Adult Day Services	☐
Homemaker	☐
Supported Living	☐
Skilled Nursing	☑
Case Management	☐
Community Integration Services	☐
Respite	☑
Transportation	☐
Supported Employment	☐
Behavioral Support Services	☐
Specialized Equipment	☐
Self-Directed Goods and Services	☐
Occupational Therapy	☐
Dietician Services	☐
Environmental Modifications	☐
Physical Therapy	☐

Facility Capacity Limit:

10 persons

Scope of Facility Sandards. For this facility type, please specify whether the State's standards address the following topics (*check each that applies*):

Scope of State Facility Standards

Standard	Topic Addressed
Admission policies	☑
Physical environment	☑
Sanitation	☑
Safety	☑
Staff : resident ratios	☐
Staff training and qualifications	☑
Staff supervision	☑
Resident rights	☑
Medication administration	☑
Use of restrictive interventions	☑
Incident reporting	☑
Provision of or arrangement for necessary health services	☑

When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:

Providers have staffing ratio expectations based upon the assessed need of the participant being served and the support that person needs as outlined in the plan of care. The residential habilitation tier levels have descriptions of the staffing expected for the person who is in that tier, but the staffing ratios are not strict 1:4 or 1:3, etc. In some instances, plans of care are approved with strict 1:1 or higher staffing, depending on the individual's needs. Other strict staffing requirements are outlined in a person's plan of care for specific life activities or in response to certain behaviors.

The state relies on the case manager to be the first-line monitor of adherence to the tiered levels of support and any specific staffing a person requires.

The BHD staff monitor staffing patterns, provider policies on staffing, and documented staffing during recertification site visits, in response to incident reports or complaints, or through other monitoring, such as the representative sample case reviews.

The standards for facilities are in Wyoming Medicaid Rules, Chapter 45.

Appendix C: Participant Services

C-2: General Service Specifications (3 of 3)

d. Provision of Personal Care or Similar Services by Legally Responsible Individuals. A legally responsible individual is any person who has a duty under State law to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the State, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. *Select one*:

- **No. The State does not make payment to legally responsible individuals for furnishing personal care or similar services.**
- **Yes. The State makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.**

Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) State policies that specify the circumstances when payment may be authorized for the provision of ***extraordinary care*** by a legally responsible individual and how the State ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the State policies specified here.*

e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians. Specify State policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one*:

- **The State does not make payment to relatives/legal guardians for furnishing waiver services.**
- **The State makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.**

Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.*

- **Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.**

Specify the controls that are employed to ensure that payments are made only for services rendered.

Limitations on the types of relatives who may furnish services:

1. BHD recognizes that there are certain circumstances where paying a relative to provide essential waiver services is justifiable by being efficient, cost effective, and beneficial to participants. These circumstances may include:
 a. A lack of available non-related staff persons in remote geographic regions, who can furnish services at necessary times and places;
 b. A participant's extraordinary care needs; and/or
 c. The need for specialized medical skills acquired by relatives.

However, it is important to ensure that there are systems to guard against conflicts of interest, inadvertent limits on participant choice, and potential fraud.

2. Relatives may furnish services as specified in Appendix C in the service defintions, scope and limitations. Relatives include a participant's biological or adoptive Parent(s), Stepparent(s), immediate and extended family members, such as a sibling, aunt, uncle, grandparent, child age 18 and over of a waiver participant, 1st cousin, or step family member, who:
 a. Is a certified Medicaid provider for the service they are providing, or hired by a certified Medicaid Provider, operating in accordance with all requirements in Wyoming Medicaid Rules Chapter 45, which includes that all certified providers and employees must pass a Background Check conducted by the state, be at least 18 years of age to work unsupervised with the participant, have training as specified in Wyoming Medicaid Rules Chapter 45, and be able to provide the care needed by the participant per the plan of care; and
 b. If a parent or stepparent operates as a certified provider, the agency shall be a Limited Liability Company, Limited Liability Partnership or a Corporation; and
 c. For Residential Habilitation services, the parent/stepparent provider shall not live in the same residence as the participant receiving residential habilitation services.
 d. Is not a spouse of the participant.
 e. Is not a legally appointed guardian of a participant age 18 and over. The guardian cannot be an officer or owner of a provider organization serving their ward and receive reimbursement.

3. Provider agencies may hire relatives to provide waiver services when the relative is qualified and trained to provide the service in accordance with Wyoming Medicaid Rules Chapter 45. Provider agencies must provide supervision and

3. Provider agencies may hire relatives to provide waiver services when the relative is qualified and trained to provide the service in accordance with Wyoming Medicaid Rules Chapter 45. Provider agencies must provide supervision and oversight of employees and ensure that claims are submitted only for services rendered and for the services, activities and supports specified in the plan of care.

4. A Participant or his/her legal representative who is self-directing waiver services may hire a relative to provide waiver services as specified in Appendix C. If the participant age 18+ hires a parent in accordance with the services its allowed, then the parent cannot be the participant's Employer of Record or legal guardian and the participant cannot opt out of support brokerage.

5. Payment to any relative specified in #2 of this section shall only be made when the service provided is not a function that the relative would normally provide for the individual without charge as a matter of course in the usual relationship among family members; and, the service would otherwise need to be provided by a qualified provider.

Controls that are employed to ensure that payments are made only for services rendered:

1. The services for which relative providers (excluding parents/stepparents) may provide include: case management, independent support brokerage, respite, personal care, companion, residential habilitation; community integration; supported living, specialized equipment, supported employment, prevocational services, and environmental modifications.

2. The services for which relative providers who are a parent/stepparent may provide include: personal care, residential habilitation (parent cannot live in same residence as participant); community integration; supported living, specialized equipment, case management (unpaid), and support brokerage (unpaid).

3. To ensure the provision of services is in the best interest of the participant, the plan of care shall be developed and monitored by a case manager without a conflict of interest to the relative provider or the participant, which means the case manager shall not be employed by or related to the relative provider or the participant (i.e. Sibling, child, grandparent, aunt, uncle, or other parent/step-parent, 1st cousin, step family, or the participant's guardian).

4. The plan shall document that services do not duplicate similar services, natural supports, or services otherwise available to the participant.

5. A schedule shall be used for documenting service delivery in accordance with Wyoming Medicaid Rules Chapter 45, which shall support the services claimed for reimbursement.

6. Documentation of services provided are reviewed by the case manager on a monthly basis to verify that services delivered align with the approved plan of care.

7. If the relative is not providing services in the best interest of the participant, the case manager shall work with the participant and appropriate team members, and the Division as needed, to choose other providers as appropriate and modify the plan of care to better suit the needs of the participant.

8. All services are observed quarterly by the case manager and reviewed for appropriateness during team meetings every six (6) months.

9. Personal care and Supported Living services reimbursed by the waiver to a relative provider cannot exceed four (4) hours per day per participant (total), if the provider lives in the same residence as the participant.
a. It is expected that for those participants living with their families, that the family members will contribute natural support and supervision, similar to how a family functions.
b. Additional units needed beyond 4 hours a day shall only be approved by the Division's Extraordinary Care Committee.

10. The amount of waiver services prior authorized by the Division shall align with the service definition in the approved waiver and shall be based upon individual need as specified in the individualized plan of care and other assessments.

11. For participants self-directing and hiring relatives, the employer must provide supervision and oversight of employees and ensure that claims are submitted only for services rendered. The Financial Management Service subagent shall ensure that claims are submitted only for services authorized in the self-directed budget allocated by case managers.

12. Case managers of participants who are self-directing some or all of their waiver services also monitor timesheets of participants to ensure that the services provided are in accordance with the participant's needs and with the plan of care, and are documented in accordance with Medicaid Documentation Standards.

13. Provider agencies may hire relatives to provide waiver services, when the relative is qualified and trained to provide the service in accordance with the Division rules. Provider agencies must provide supervision and oversight of employees and ensure that claims are submitted only for services rendered as specified in the plan of care.

14. Relatives that are paid to provide services as outlined above must meet the same requirements and qualifications as other providers/staff and are subject to the same oversight levels as outlined in the waiver and applicable regulations and policies.

15. All claims are processed through the Medicaid Management Information System (MMIS) and are subject to post-payment validation. When problems with service validation are identified on a post-payment review, erroneous or invalidated claims are voided from the claims payment system and the previous payment recouped from the provider.

Other policy.

Specify:

f. Open Enrollment of Providers. Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:

BHD within the state Medicaid Agency has continuous open enrollment of waiver service providers. Information on how to become a Waiver Medicaid provider is available on the Division's website. When contacted by interested provider applicants, BHD staff reviews the process and requirements of becoming a waiver provider, including the requirements that the provider sign a Medicaid Provider Agreement, complete background checks, and other required trainings. If BHD staff meet with the applicant in person the enrollment packet is given to them during the meeting. If the applicant contacts the BHD by phone an enrollment packet is sent to them by mail. The application is also available on-line. BHD staff work with the applicant throughout the enrollment process, keep the applicant informed of what is still pending, and are available to answer questions. After all requirements of certification have been met, BHD forwards the enrollment packet to Xerox, the Medicaid billing representative. Xerox reviews the enrollment packet to assure the applicant has completed all the required paperwork, including the Medicaid Provider Agreement, and verifies the applicant meets the requirements to become a Medicaid provider. Xerox then generates the provider number and notifies BHD that the applicant has been assigned a provider number. All providers certified to provide waiver services are required to have a current provider agreement in place with the State Medicaid Agency.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Qualified Providers

The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.

i. Sub-Assurances:

a. ***Sub-Assurance: The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
10 Percentage of Waiver providers meeting all state certification requirements (the number of waiver providers initially certified who meet all the requirements divided by the number of providers initially certified to provide waiver services)

Data Source (Select one):
Other
If 'Other' is selected, specify:
IMPROV, BHD's electronic provider management system

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis*(check each that applies):*
Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
11 Percentage of Waiver providers completing recertification process by their end certification date (the number of providers recertified by end certification date divided by the number of providers certified to provide services on waiver

Data Source (Select one):
Other
If'Other' is selected, specify:
IMPROV

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
12 Number and percentage of Waiver providers sanctioned due to noncompliance with rules by type of sanction – suspension, civil monetary penalty etc. (the number of providers sanctioned due to noncompliance with rules divided by the total number of providers)

Data Source (Select one):
Other
If 'Other' is selected, specify:
IMPROV

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Other** Specify:

b. ***Sub-Assurance: The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.***

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
13 Wyoming does not allow payment to non-certified providers except through the financial management service Fiscal/employer agent. (Proportion of non-certified providers receiving payment for waiver services divided by the number of providers enrolled as waiver providers.)

Data Source (Select one):
Other
If'Other' is selected, specify:
IMPROV

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. ***Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.***

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
14 Percentage of Waiver providers initially certified who completed initial provider training (the number of new providers receiving training divided by the of new providers initially certified)

Data Source (Select one):
Other
If'Other' is selected, specify:
IMPROV

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis*(check each that applies):*
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
15 Percentage of Waiver providers required to complete retraining in a specific area as specified in state requirements and the approved waiver (the number of providers required to complete retraining divided by total number of Waiver providers)

Data Source (Select one):
Other
If 'Other' is selected, specify:
IMPROV

Responsible Party for data collection/generation*(check each that applies):*	Frequency of data collection/generation*(check each that applies):*	Sampling Approach*(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis*(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis*(check each that applies):*
	☐ **Other** Specify:

Performance Measure:
16 Percentage of Waiver participants surveyed that report staff has adequate training to meet his/her needs (the number of Waiver participants who affirm staff have adequate training divided by the total number of participants interviewed)

Data Source (Select one):
On-site observations, interviews, monitoring
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	Frequency of data collection/generation*(check each that applies):*	Sampling Approach*(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95% +/- 5%
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: Amount of sample reviewed every two years is combined with like waiver populations served by BHD
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis*(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: aggregation of data occurs over two year period but a report is generated annually

Responsible Party *(check each that applies):*	Frequency of data aggregation and analysis *(check each that applies):*

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

Initial provider certification process
Provider applicants must meet all requirements for the services they are requesting certification in before becoming a certified provider. This information, including results of background checks, CPR certification, First Aid certification, and training, is tracked in IMPROV.

No provider applicant is allowed to become certified until all required documentation and results of background checks have been received. Data from IMPROV is generated to report on trends within the provider certification process.

2. Provider recertification process
Providers are required to be recertified between 1 and 3 years depending on the service they provide and depending on the results of their current recertification. The recertification process includes verification the provider is complying with rules & regulations pertaining to qualifications for services, staff/provider training, policies, procedures and practices for incident reporting, restraint usage, documentation and billing standards, HIPAA/Confidentiality, emergency procedures, inspections, rights and rights restrictions, and appropriately implementing plans of care. The results of the recertification outline any specific issues of non-compliance, information for submitting corrective action plans, and specific time lines to remedy non-compliance issues. BHD works with providers to ensure compliance is met including providing individual consultation and when necessary, sanctioning the provider due to not adhering to time lines or failure to meet compliance. The results of the recertifications are tracked in IMPROV, including areas of non-compliance resulting in recommendations, dates of submission and approval of corrective action plans, and verification that corrective action plans have been implemented appropriately. Data is generated from IMPROV to track trends in areas of non-compliance, submissions of corrective action plans, and completion dates of recertifications.

3. Complaint process
Participants, guardians, and providers can file a complaint against another provider. Complaints received by BHD are entered in IMPROV, and follow-up actions are determined based on priority levels according to the type of complaint. If BHD determines there is provider non-compliance with rules and regulations through a complaint, the complaint is substantiated and the provider is required to submit a corrective action plan that is tracked through IMPROV. BHD provides notification to the complainant regarding if the complaint was found substantiated or not substantiated.

4. Incident reporting process
Incidents reported to BHD are tracked through IMPROV, and may result in a criminal case through law enforcement, an investigation by DFS, and/or an investigation by BHD. Follow-up actions by BHD are based on priority levels and type of incident. If BHD determines there is provider non-compliance with rules and regulations through complaints or incidents the complaint or incident is "substantiated" and the provider is required to submit a corrective action plan that is tracked through IMPROV.

5. Internal referral process
BHD staff who attend team meetings or review and approve plans of care may identify provider noncompliance with rules and regulations through one of these processes. When this occurs, BHD submits an internal referral through IMPROV, and follow-up actions are determined based on priority levels type of the internal referral. If BHD determines there is provider non-compliance with rules and regulations, the internal referral is substantiated and the provider is notified by the Division to submit a corrective action plan that is tracked through IMPROV.

If a provider repeatedly fails to submit an acceptable Corrective action plan, the Division has the authority to sanction the provider. Sanctioning can include freezing a provider's admissions, suspending a provider, imposing a monitor, imposing a civil monetary penalty, removing participants at significant risk, requiring additional training, decertifying a provider, as well as other sanctions. Information on providers who have been sanctioned is tracked in IMPROV and data generated on sanctions. Providers can also be decertified if they are convicted of a crime against a person or if they are listed on the Abuse Central Registry.

Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.

BHD assesses providers' adhering to training requirements through the same processes listed above. A provider applicant is not certified as a provider until they have completed the required training. All certified providers are then responsible for ensuring that they have had participant specific training prior to working with a participant for all waiver participants they are providing services to. If concerns with provider training are found through one of these processes discussed previously, the provider is required to submit a Corrective Action Plan addressing the non-compliance with in regards to training. The provider is responsible for receiving training within the time frames specified in the Corrective Action Plan. In addition, the Division also has the authority to require a provider to complete retraining in a specific area when concerns continue to be identified. This information is tracked through IMPROV and reports are generated on the number of providers requiring retraining, the number of providers receiving recommendations concerning training, and the number of new providers who completed the required training.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party *(check each that applies):*	Frequency of data aggregation and analysis *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**

Responsible Party *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Qualified Providers that are currently non-operational.

- ◉ **No**
- ○ **Yes**

Please provide a detailed strategy for assuring Qualified Providers, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix C: Participant Services

C-3: Waiver Services Specifications

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

a. Additional Limits on Amount of Waiver Services. Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*select one*).

- ○ **Not applicable**- The State does not impose a limit on the amount of waiver services except as provided in Appendix C-3.
- ◉ **Applicable** - The State imposes additional limits on the amount of waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the amount of the limit. (*check each that applies*)

☐ **Limit(s) on Set(s) of Services.** There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.
Furnish the information specified above.

☑ **Prospective Individual Budget Amount.** There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.
Furnish the information specified above.

(a) The waiver services to which the limit applies:
The Individual Budget Amount (IBA) assigned to a participant applies to any of the waiver services he/she chooses to have on their individualized Plan of Care.

Individuals not currently receiving residential services may not use the home service budget for residential services unless they meet the targeting criteria for the service. The formula for an IBA when a person has residential services was developed by separating out home service needs and day service needs. The funding amounts per level of service need score are determined by the posted rate for the service and the average number of units used in that service annually. Then the home budget is added to the day service budget that uses different rates and units depending on the level of service need score. If the person does not have approval for residential habilitation by meeting the targeting criteria specified in the service definition and approved by ECC, this home budget will not accommodate the cost of residential habilitation services.

(b) The basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject:

The Behavioral Health Division (Division) is using a new IBA methodology for assessing need and determining budgets for new IBA participants which provides a stable and equitable foundation on which to build a stronger, more person-centered waiver system that promotes greater community integration, employment support, and independence. The new method will be used as new people come on to the waiver and receive a funding opportunity.

For existing waiver participants, the former IBA methodology from the previous waiver cycle will be used. The prospective individual budget amount is based upon historical annual plan units from 2012 (utilization) multiplied by the posted service rates. The rates for all ABI Waiver services are posted on the BHD website.

Once the individualized budget is first determined or is changed, the participant, the case manager and the team work together to develop or revise the plan of care so that needed waiver services are allocated within the individualized budget and non-waiver services are identified. The individualized budgeted amount does not limit specific waiver services. If the participant and/or guardian, with support from the team, identifies that the plan of care developed within the budgeted amount will not meet the participant's health and welfare needs the case manager can request additional funding on behalf of the participant through the BHD Extraordinary Care Committee.

The new IBA methodology uses the nationally recognized Inventory for Client and Agency Planning (ICAP) to base budgets on a participant's assessed needs. The ICAP has been utilized on each person participating on a waiver and on the wait list for waiver services for over 20 years in Wyoming. The ICAP assessment determines an individual's level of functioning for Broad Independence and General Maladaptive Factors. The sub-scores in the ICAP also measure a person's functioning in the areas of social and communication skills, personal living skills, motor skills and community living skills.

A participant's IBA is determined by two factors:

A) Assessing the Level of Service Need assigned to a person based on independent assessments of need, including their ICAP scores, supplemental assessments, prior service utilization. The Level is assessed on a continuous scale between 1 and 6; and
B) Living Situation: family home, independently or semi-independently, or in residential services; and

A) Assessing the Level of Service Need
For each individual on the Comprehensive Waiver, the IBA algorithm will use three (3) separate 'passes' or 'looks' to assess the level of need on a continuous scale between 1 and 6 (i.e., decimals will be allowed; someone may be assigned a level of 3.5 instead being rounded to a discrete 3 or 4).

• The first pass determines a level based on the overall ICAP Service Score alone. The equation mapping Service Score to Level of Service is:

Level of Service= -0.0619×Service Score+6.827

• The second pass considers the ICAP sub-scores corresponding most closely to overall behavioral and medical needs (General Maladaptive score and Personal Living domain score, respectively). The equation mapping these two (2) sub-scores to Level of Service is:

Level of Service=(0.0223×General Subscore)+(-4.21×〖10〗^(-8)×〖Personal Living Subscore〗^3)+(-8.12×〖10〗^(-10)×〖Personal Living Subscore〗^3 ×General Subscore)+7.2457

The highest of the first and second passes is chosen.

The third pass, based on generated flags, considers other independent assessment information on the person, based on specific assessment questions and prior service utilization. These flags may result in an adjustment of the final level of service need--necessitating an adjusted budget in order to properly reflect the person's assessed needs.

Methodology
The formulas matching ICAP scores and sub-scores to levels (the first two passes) were determined by surveying 16 experts both in-house and at WIND (Wyoming's UCEDD and ICAP contractor) using a 'calibration dataset' of 140 individuals and ICAP scores chosen from the entire waiver database. In their surveys, experts assigned Levels of Service to each individual and their ICAP scores.

Half of the calibration dataset was composed of either very high-need or very low-need individuals to 'anchor' both sides of the algorithm. The remainder of the dataset was randomly chosen from the Developmental Disability (DD) and Acquired Brain Injury (ABI) population.

The survey results were aggregated to average the expert level ratings for each data point. Linear regression techniques were then used to predict these expert averages using various ICAP scores for the first two passes.

Results from the regression models are below.

First pass

```
      Source |       SS       df       MS              Number of obs =     140
-------------+------------------------------           F(  1,   138) = 3234.25
       Model |  295.837208     1  295.837208           Prob > F      =  0.0000
    Residual |  12.6228739   138  .091470101           R-squared     =  0.9591
-------------+------------------------------           Adj R-squared =  0.9588
       Total |  308.460082   139  2.21913728           Root MSE      =  .30244

------------------------------------------------------------------------------
       level |      Coef.   Std. Err.      t    P>|t|     [95% Conf. Interval]
-------------+----------------------------------------------------------------
     service |  -.0619004   .0010884   -56.87   0.000    -.0640526   -.0597482
       _cons |   6.827182   .0606684   112.53   0.000     6.707222    6.947142
------------------------------------------------------------------------------
```

Second pass

```
      Source |       SS       df       MS              Number of obs =     140
-------------+------------------------------           F(  3,   136) =  634.85
       Model |  287.901569     3  95.9671896           Prob > F      =  0.0000
    Residual |  20.5585134   136  .151165539           R-squared     =  0.9334
-------------+------------------------------           Adj R-squared =  0.9319
       Total |  308.460082   139  2.21913728           Root MSE      =  .3888

------------------------------------------------------------------------------
       level |      Coef.   Std. Err.      t    P>|t|     [95% Conf. Interval]
-------------+----------------------------------------------------------------
     general |   .0223222   .0148069     1.51   0.134    -.0069594    .0516039
    personal3 |  -4.21e-08   1.16e-09   -36.33   0.000    -4.44e-08   -3.98e-08
```

```
    genpers | -8.12e-10   1.52e-10    -5.34   0.000    -1.11e-09   -5.11e-10
      _cons |  7.245767   .1155979    62.68   0.000     7.017165    7.474369
------------------------------------------------------------------------------
```

The third pass -- considering other assessments, prior service utilization and specific assessment questions -- was developed using the Division's in-house clinical and psychological expertise.

Matching Levels of Need to Individualized Budgets
Once the assessed Level of Service has been translated to a continuous scale from 1-6, IBAs can be developed based on (A) this assessed level and (B) living situation (e.g. with family, living independently, or in residential habilitation).

The budget levels established by the Division for discrete levels (e.g. a "1" a "2" or a "3") will remain in effect. Dollar amounts in between these levels, however, will be based on the curve that connects discrete levels. For example, if a Level 1 budget for day habilitation for an individual in supported living who is over 21 is $10,000, and a Level 2 budget is $20,000, the budget for an individual assessed as a 1.5 will be close to $15,000.

Assigning IBAs based on fractions of a level ensures fairness by not penalizing those who fall close to a rounding point (e.g. a 3.49 being assessed as a Level 3, where a 3.51 is assessed as a Level 4).

B) Living Situation

For those living with family, the budget for each Level is based on:

Hourly rate for personal care services×Estimated required hours of service (daily and weekly)

As a person's level of service need increases, the hours and days of service needed increase from about three (3) hours a day for three and three-quarter (3.75) days a week on the low end to seven (7) hours a day for five (5) days a week on the high end. Service rates for respite, child habilitation, or other services utilized by families are lower than the personal care rate, so the family may have more hours of service available to them, depending on how they want to budget their services. The use of the budget is not limited to the hours listed in the assumption.

For people living independently or semi-independently, the budget for each Level is based on:

Daily supported living rate for each Level of Service×Estimated required days each week service is required

Day service budgets are based on:

Estimated required hours of day services×15 minute rate for each Level

For people living in residential services, the budget for each level is based on:

Daily residential habilitation rate for each Level of Service×Estimated required days each week service is required

Day service budgets are based on:

Estimated required hours of day services×15 minute Community Integration rate for each Level

IBA Reviews and Appeals.
If a participant's Plan of Care team believes a participant's budget does not reflect his or her assessed needs, they may request a review by a Participant Support Specialist or the Division's Clinical Review Team (CRT). The request must accompany additional information on other assessed needs the Plan of Care team does not think are accurately captured in the ICAP. The CRT will include the Division's Clinical Psychologist, the Medicaid Medical Director, the Division's Psychiatrist, and other specialists as needed.

The CRT has the authority to request additional assessments, including a new ICAP, a Supports Intensity Scale, or another appropriate, standardized assessment targeted for a specific diagnosis or condition. The additional assessment in these cases may provide more detailed information on the person's support needs and assist the CRT in evaluating the need for a different budgeted amount. Information from the ICAP, along with information from other assessments, and information submitted by the participant's team, will be used to make the final decision on the request for a budget change. Given the change in the budget methodology, the additional assessments and information reviewed by the CRT may result in a budget increase, decrease, or no change.

If a person needs a budget in excess of the cost limit for the ABI Waiver, the budget will be approved by the Division's CRT or Extraordinary Care Committee (ECC). The Division will also work with the participant's team on other treatment, behavior or medical support services, and other service options to try to improve the person's condition and lower the cost of services over a two (2) to three (3) year period.

If the budget is lowered based on assessed needs approved by the CRT or ECC, and the participant's team does not want to continue to provide services, then the providers must give the participant a 30-day notice. The Division is notified if a provider gives a 30-day notice and ensures the case manager and Division staff look for other waiver providers or options so the participant is served appropriately.

No one will lose eligibility as a result of their budget being higher than the new limits for this waiver.

(c) How the limit will be adjusted over the course of the waiver period:
The Division will review the methodology and algorithm used to set budgets each year to determine if the IBAs assigned are reflective of the assessed service needs of the waiver participants. The Division will also review the IBA adjustments requests that have been submitted (whether approved or denied) in order to analyze the reasons for adjustment requests and determine whether a factor in the model is missing or incorrectly weighted.

(d) Provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state:
An IBA will be assigned to the participant according to their Level of Service Need based on the scores from the ICAP assessment pertinent to the IBA methodology. Upon completion of the IBA process, the participant will be notified of the IBA through their case manager.

NOTE: For the first year of the waiver renewal, the IBAs will be issued as plans of care come due starting October 1, 2014.

A participant or Plan of Care team may request a formal review of the participant's IBA through a Budget Review Questionnaire submitted by his/her case manager. The Plan of Care team is asked to review the ICAP and any supplemental assessments, and then provide supporting documentation to substantiate an individual's need for placement for a different Level of Service Need score. The supporting documentation is reviewed as well as the person-centered Plan of Care, Positive Behavior Support Plans, risk assessments and any other collateral documentation needed to analyze the individual's Level of Service Need category. The Plan of Care team must first review the functional assessment findings and provide any other supporting documentation that might lead to a needed IBA adjustment. When requested, reviews are conducted by the CRT at the Division. If approved, adjustments and/or recommendations are provided by the CRT.

IBA adjustments may also occur when the participant has a qualifying life changing event. The participant's Plan of Care team may request additional funding by following the ECC process if the situation meets ECC criteria. A temporary IBA adjustment allows the participant to request short term increases in funding beyond the IBA, if specific conditions apply and all other resources available to the person have been accessed and the Plan of Care team has explored all other options in the person's environment, circle of support and community. Qualifying conditions are defined by Division policy and consist of a drastic change in medical or behavioral needs, a personal crisis or an emergency change in living arrangement. The temporary IBA adjustment form provides the participant and Plan of Care team the ability to request additional funding for a short amount of time to meet their needs that are outside the original assigned IBA. Permanent adjustments may be approved by the ECC as well, with evidence of the change in assessed needs.

(e) The safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs:
The Division reserves a portion of the waiver budget for emergency increases to an IBA. If the IBA increase needed would exceed the cost limit for the waiver, the participant and his/her Plan of Care team may receive an increased IBA for a period of one (1) to two (2) years, and may also be notified of other waiver options and programs in the state for which they are possibly eligible, in order to meet the person's health and safety needs.

Funding requests, which are modified or denied, are eligible for a fair hearing, and the participant is notified of this right. After approving additional funding, the Division may complete follow-up monitoring to assure the funds are being utilized appropriately and the assessed need continues to exist for the participant.

(f) How participants are notified of the amount of the limit:
Prior to each annual Plan of Care date and for initial placements on the waiver, the case manager is notified in the Electronic Medicaid Waiver System (EMWS) of the assigned budget and the case manager communicates the budget to the participant and guardian in order to plan services. Any adjustments to budgets based on legislative decisions or other factors will go through the same notification process.

Participants will be notified of their assigned budget prior to transitioning to the new budget. The participant needs approximately 90 days from the date of the assigned IBA to have a Plan of Care team meeting, develop the Plan of Care, and submit it to the Division for approval and service prior authorization. If a participant disputes the IBA assignment and files a budget review questionnaire or files an appeal, the person may need an additional 30 days or more to accommodate the Division's budget review process.

☐ **Budget Limits by Level of Support.** Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.
Furnish the information specified above.

☐ **Other Type of Limit.** The State employs another type of limit.
Describe the limit and furnish the information specified above.

Appendix C: Participant Services

C-5: Home and Community-Based Settings

Explain how residential and non-residential settings in this waiver comply with federal HCB Settings requirements at 42 CFR 441.301(c)(4)-(5) and associated CMS guidance. Include:

1. Description of the settings and how they meet federal HCB Settings requirements, at the time of submission and in the future.

2. Description of the means by which the state Medicaid agency ascertains that all waiver settings meet federal HCB Setting requirements, at the time of this submission and ongoing.

Note instructions at Module 1, Attachment #2, HCB Settings Waiver Transition Plan for description of settings that do not meet requirements at the time of submission. Do not duplicate that information here.

1. Description of the settings and how they meet federal HCB Settings requirements, at the time of submission and in the future.

ABI waiver participants live in family homes, independently, semi-independently and receive supported living, and in residential group homes, host homes, or apartments. 43 settings were evaluated serving participants in provider operated settings.

Results of the setting analysis to date:
43 Settings were evaluated for the ABI population and they serve people with 107 ABI participants total in those settings.
0 are fully in compliance with the new HCB regulations.
43 are not in compliance, but with modifications they should be in compliance at the end of five year transition timeline.

The areas on non-compliance are mostly related to access to food, ability to have an unregimented day, lack of integration in the settings, and having a signed lease or key. All areas that can be modified to come into compliance.

Further analysis of the settings through stakeholder surveys, onsite visits, case management reports, and participant and guardian interviews will be conducted during 2015 and 2016 to ensure that any setting with areas of non-compliance will be addressed by providers. No settings have been determined at this time to be non-HCB at this time and subject to heightened scrutiny by CMS.

Public comments overwhelmingly recommended that the Division focus on assuring services are supporting people to be integrated in the community instead of focusing on the location where services are delivered. From the initial provider survey, settings

Public comments overwhelmingly recommended that the Division focus on assuring services are supporting people to be integrated in the community instead of focusing on the location where services are delivered. From the initial provider survey, settings were flagged for concern due to location issues such as industrial or commercial zoning areas or a rural area. After more analysis, the state decided these flags were an unfair assumption. They are now considered an "indicator" of possible segregation or isolation where the state needs more information to ensure the person's in those settings have services provided in compliance with the new rules. The flags were removed because providers and family made the case that the zoning characteristic was not an accurate indicator of segregation or isolation and not all industrial zones are created equal in a city. Some locations in these zones are close to other businesses that are safely and regularly visited. Some zones are further from businesses that can be frequented. Providers and family members in these locations mentioned that they still get to access the community and get out more often than other family members living at the family home, so if a provider can provide regular access to the community, the provider setting should not be eliminated from HCB by location alone. Additionally, towns and cities can change the zoning of different areas quickly and easily, but that zones are not always updated to ensure that they reflect the characteristics of an area. This renders the method of enforcing the new rules ineffective, because a provider would only need to their building's zoning changed. The Department of Health's leadership team agreed to make these changes and said that we would not disqualify a setting based on this characteristic alone. In our additional analysis in 2015, providers of settings that may appear to isolate or segregate, or are located on or adjacent to an institution, must give evidence on how people access the community, how often, and what they do so we can help them improve in this area or make modifications to their business model to meet the integration standards. Moreover, many people like to live in Wyoming due to its rural nature. Therefore, for residences that are not near other residences or near a community with businesses, the setting cannot be ruled as non-HCB by location alone. The provider must still provide evidence to the state on how they help the person access the community, provide transportation, and integrate the person (as well as the other standards in the new rule.)

Also, the non-residential settings that appear to segregate people with disabilities from the general public will not be disqualified from being considered HCB on this fact alone; the setting will be evaluated for other characteristics and individual experiences before being considered non-HCB.
Rather than requiring specific milestones each year, providers will be issued a report of areas of non-compliance and will complete a transition plan with milestones and timelines each year. They will have the rest of the five years to come into compliance with the standards but must make progress each year. State monitoring processes will oversee the provider's compliance to their own transition plans.

2. Description of the means by which the state Medicaid agency ascertains that all waiver settings meet federal HCB Setting requirements, at the time of this submission and ongoing.

TRANSITION TIMELINE AND MILESTONES
The following action plan shows how the state Medicaid agency will ascertain that all waiver settings meet federal requirements now and within the timeline allowed under the new HCB Setting regulations.

Year 1 - Milestones for March 17, 2014 and March 16, 2015

1. Milestone: By June 2014 and ongoing until 2016, a Transition Stakeholder team has been established and meets monthly. This stakeholder team that represents a cross section of the waiver providers, participants, and agency staff will meet to discuss and set standards and complete self-assessments for Wyoming and help with ongoing issues.
Action items:
- Request members & charter team expectations
- Meet regularly, monthly if possible
- Have members from multiple levels within the waiver systems, advocacy groups, participants, guardians, providers and have various parts of the state represented.

2. Milestone: Starting in November 2014, the state will inventory provider settings and conduct an assessment of compliance with HCB standards in federal rules. Settings must be evaluated to see if they meet the standards and are required to fix the areas of non-compliance in order to remain HCB providers according to the state's approved transition plan. Settings will be considered one of the following:
a) In Compliance (fully align with the Federal requirements)
b) Does not comply with the Federal requirements and will require modifications
c) Cannot meet the Federal requirements and require removal from the program and/or the relocation of individuals
d) Presumptively non-home and community-based but for which the state will provide justification / evidence to show that those settings do not have the characteristics of an institution and do have the qualities of HCBS (to be evaluated by CMS through heightened scrutiny process
Action Items:
- Develop provider survey to assess settings (first one done in July 2014, second one being done in January 2015 until March 2015)
- Providers complete it by February 28, 2015
- State and team review and analyze survey responses by March 3, 2015
- Determine compliance for each setting and the remediation and improvements that are needed and issue final report to providers by April 15, 2015
- Summarize results for CMS and amend the waivers beginning May 15, 2015 with developing the report, issuing public comment and notice to tribes, and submitting amendment in July. See Milestone 4.

3. Milestone: Starting in October 2014 and throughout 2019, the state will conduct additional analysis of provider settings with participant, guardian, case manager, and state staff respondents for validity testing of the provider settings and compliance with federal requirements.
Action items:
- State staff analysis of provider surveys by March 31, 2015
- State staff review stakeholder survey information from October 2014 through May 2015
- Develop and disseminate surveys to participants, guardians, case managers, and other stakeholders – Starting in October 2014 and through March 31, 2015 initially, then ongoing through Jan 2019. Review annually in August.
- Collect and analyze responses from stakeholders by March 31, 2015 then ongoing as more surveys are submitted to the Division. Review annually in August.
- Use the Representative Sample Case Review to look at data on participant's satisfaction with service settings, integration, and informed choice – update process starting in July 2015. Review annually in August.
- Use Case Management Quarterly Report data in EMWS to evaluate integration, progress on objectives, satisfaction with services, and employment data - updated process starting in July 2015. Review annually in August.
- Settings that are found to meet any of the following criteria will be subject to the heightened scrutiny process by CMS if requested by the provider and approved by the Department by October 2015 or anytime thereafter before December 2018:
a) The setting is designed to provide people with disabilities multiple types of services and activities on-site, including housing, day services, medical, behavioral and therapeutic services, and/or social and recreational activities.
b) People in the setting have limited, if any, interaction with the broader community.
c) Settings that use/authorize interventions/restrictions that are used in institutional settings or are deemed unacceptable in Medicaid institutional settings (e.g. seclusion).

4. Milestone: In July 2015, the state will submit an amendment to CMS that summarizes the specific rules, service definitions, requirements, policies, compliance for each setting, remediation improvements needed, and changes to processes, provider or facility requirements.
Action items:
- By May 15, 2015, Draft the inventory and compliance report, and other amendment components
- By May 22, 2015, issue public notice and notice to tribes of amendment
- By July 1, 2015 Analyze public comment and make any needed changes to amendment

- By July 1, 2015 Analyze public comment and make any needed changes to amendment
- By July 22, submit amendment to CMS

5. Milestone: In October 2014, the state conducted Public Forums to review transition plan and gather public input, as required by CMS.
Action items:
- Scheduled forums for October 2014
- Put transition information together
- Presented at forums and receive input on plan

6. Milestone: In November 2014, developed the ABI waiver transition plan to submit to CMS and will evaluate every six months.
Action items:
- Transition plan finalized -October 2014
- Summarize public comment and make changes to draft plans as appropriate –Nov 2014
- Discuss comments with Task Force October 2014
- Providers with areas of non-compliance identified in initial survey results-Nov 2014
- Due dates for remediation identified – March 2015

7. Milestone: By September 2014 and ongoing quarterly through the next five years, the state will develop and deploy a communication strategy to inform and educate participants, guardians, providers, legislators on the new standards and requirements.
Action items:
- Summarize decisions from Transition Task force
- Communicate information to public in multi-media approaches
- Reach all audiences with consistent message and needed changes to state rules and policies
- States must ensure the full Transition Plan is available to the public for public comment, including individuals receiving services, individuals who could be served, and the full stakeholder community.

8. Milestone: By March 31, 2015, the state will assess state service definitions, rules, and facility requirements for compliance and determine areas that need remediated. The state must ensure its own policies, services, rules, or requirements are not promoting services in a manner that violates the new federal laws. Any areas of non-compliance on the state side must be addressed as well.
Action Items:
- Critique all waiver service definitions, waiver rules, and facility requirements to see where they are out of compliance with federal rules by March 31, 2015.
- Adjust the services, rules, or facility requirements with involvement from a stakeholder team by July 22, 2015, filing additional waiver amendments or changing rules as necessary.

9. Milestone: By February 2015 and ongoing through 2019, the state will develop a plan for monitoring and enforcing ongoing compliance with the new standards and provider requirements. States must ensure that providers meet the milestones in the ABI transition plan and continue to meet the standards on an ongoing basis.
Action items:
- By July 2015, the state will adjust provider monitoring and on-site visits to ensure compliance with transition plan deadlines to reach compliance with HCB setting standards.
- By July 2015, the state will develop a provider self-assessment to help providers diagnose issues that should be improved or fixed in their organization.
- By October 2015, the state will issue additional information to case managers to help monitor service delivery according to the new standards and report individual progress or issues to the Division.
- By July 2015, the state will use monitoring processes to address areas of non-compliance with standards through certification processes and incident/complaint monitoring processes
- By July 2015, the state will modify and use the Representative Sample Case Review to look at data on participant's satisfaction with service settings, integration, and informed choice
- By July 2015, the state will use the Case Management Quarterly Report data to evaluate integration, progress on objectives, satisfaction with services, and employment data

Year 2 - Milestones for March 17, 2015 to March 16, 2016

10. Milestone: By October 2015, the state will update state rules and laws where required to meet new standards. The state needs to ensure the rules and laws do not conflict with the federal regulations.
Action items:
- The state seeks stakeholder input to adjust rules to meet new standards.
- Rule changes are made according to state procedures.
- State works with legislators to adjust statutes as needed.

11. Milestone: By October 31, 2015 (or anytime thereafter), any provider HCB settings that are fully assessed by the state and found to meet one of the following qualities will be presumed institutional in nature:
a) The setting is designed to provide people with disabilities multiple types of services and activities on-site, including housing, day services, medical, behavioral and therapeutic services, and/or social and recreational activities.
b) People in the setting have limited, if any, interaction with the broader community.
c) Settings that use/authorize interventions/restrictions that are used in institutional settings or are deemed unacceptable in Medicaid institutional settings (e.g. seclusion).
If notified of this status, the provider may ask the state to request approval from CMS to be considered HCB because of the other HCB qualities and individual experiences that meet the federal standards. Through the ongoing analysis of settings, if any setting is found to be Non-HCB based on the new rules, but the state determines that evidence proves it should be considered HCB, the state must provide the evidence to CMS and the setting is subject to approval through the heightened scrutiny process. Requests to CMS, if determined appropriate by the state, will be submitted during November 2015 and go through the heightened scrutiny process.
Action items:
- By March 31, 2015 the preliminary HCB Setting analysis will be completed to determine which settings are out of compliance and are "flagged" for corrective action
- By April 15, 2015 the state will issue providers a report of findings and require the provider to develop a detailed corrective action plan with a transition plan by October 2015.
- By October 31, 2015 (or any time after this deadline if compliance issues are found), if a setting meets one of the listed criteria in this milestone, the setting may be subjected to the heightened scrutiny process by CMS.
- For settings found to be institutional in nature, the provider may request the state submit an exception to CMS and will provide evidence of how each setting:

a) Supports full access to the greater community to the same degree as individuals not receiving Medicaid HCBS.
b) Is selected by the individual from options including non-disability specific settings.
c) Ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint.
d) Optimizes individual independence in making life choices including daily activities, physical environment, and with whom to interact.
e) Facilitates individual choice regarding services and supports, and who provides them.

- The state will submit a detailed request with evidence by October 31, 2015 for settings that are deemed not HCB, which the state elects to be subject to the heightened scrutiny process by CMS. If any apply, the request will be submitted by November 30

 The state will submit a detailed request with evidence by October 31, 2015 for settings that are deemed not HCB, which the state elects to be subject to the heightened scrutiny process by CMS. If any apply, the request will be submitted by November 30, 2015 or at any time a different decision is made by the state for a setting.

12. Milestone: By April 15, 2015, each provider with an HCB setting that has areas of noncompliance with the new standards found by state staff will be issued a Corrective Action Plan for any of the following standards where their residential setting is not in compliance.
- A lease or written residency agreement with each participant
- Each individual has privacy in their sleeping or living unit
- Units have lockable entrance doors, with the individual and appropriate staff having keys to doors as needed
- Individuals sharing units have a choice of roommates
- Individuals have freedom to furnish and decorate within the lease/agreement
- Individuals have freedom and support to control their schedules and activities and have access to food any time
- Individuals may have visitors at any time
- The setting is physically accessible to the individual

Providers will be able to uniquely adjust or restructure their business to meet the standards.
Action items:
 By March 31, 2015, a full setting analysis completed to determine which setting are out of compliance and are “flagged” for corrective action
 By April 15, 2015, Providers will be issued a report of findings and areas that need corrections
 By October 31, 2015, each provider’s transition plan must be submitted to the Division for approval and must include milestones and timeframes that outline how and when they will correct each requirement by December 1, 2018.
 Providers have until October 1, 2018 to come into compliance in all areas. Ongoing from October 2015 to October 2018, the state will meet with each provider that has a setting found to be in jeopardy of noncompliance and requiring disenrollment in 2019 to discuss all options, areas to improve, and meet with participants, guardians and stakeholders as necessary.

13. Milestone: By October 2015, any provider found out of compliance with an HCB standard in any setting must develop and implement a transition plan to make changes in order to meet the standards. The provider must ensure the policies and practices of their organization are changed where appropriate and that board members, staff, participants and guardians are aware of the systemic changes. Providers will be able to uniquely adjust or restructure their business to meet the standards within the four years left in the transition plan, but must report annual progress on milestones.

Action Items:
 By April 15, 2015, providers will be issued a report of where they are not in compliance with specific settings.
 By October 31, 2015, providers must develop and submit a detailed action plan with milestones and timelines each year that outline the changes or actions that will be taken in order to come into full compliance with all HCB standards December 1, 2018. The transition plan will require providers develop or update operating policies and procedures to address how they will demonstrate that each setting:
a) Is integrated in and supports full access to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community to the same degree as individuals not receiving Medicaid HCBS.
b) Is selected by the individual from options including non-disability specific settings.
c) Ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint.
d) Optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices including daily activities, physical environment, and with whom to interact.
e) Facilitates individual choice regarding services and who provides them.
 By October 1, 2015, the state will develop provider self-assessment to assist the provider in adjusting business practices to meet the standards.
 From July 2015 and ongoing, the state will work with providers to make adjustments to the action plan, if needed.
 By December 1, 2015 the state must approve each provider transition plan.

14. Milestone: By March 1, 2016, participants who need a modification to a right specified in the new standards must have the modification or restriction identified and documented in a signed plan of care approved by the state according the requirements listed in § 441.301(c)(4)(vi)(A) through (D). Participants must have their rights protected. Any modification to their rights must be fully documented and explored by the team according to the new HCB standards.
Action items:
 By July 1, 2015, the state will revise the electronic plan of care to include the new standards for restricting a person’s right.
 By January 31, 2016, the Case manager will work the participant’s plan of care team to inform the participant and guardian of their rights in the new regulations.
 By February 1, 2016, the team must address the following items for any modification or restriction to a person’s right in the plan of care:
a) Identify a specific and individualized assessed need.
b) Document the positive interventions and supports used prior to any modifications to the person-centered service plan.
c) Document less intrusive methods of meeting the need that have been tried but did not work.
d) Include a clear description of the condition that is directly proportionate to the specific assessed need.
e) Include regular collection and review of data to measure the ongoing effectiveness of the modification.
f) Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.
g) Include the informed consent of the individual.
h) Include an assurance that interventions and supports will cause no harm to the individual.
 By February 1, 2016, the modifications to the plans of care will be submitted to the Division for review and approval by March 1, 2016.

15. Milestones: By March 1, 2016, the participant’s team documents in the plan of care, which is signed by the participant or guardian, how the HCB setting(s) chosen in the plan:
a) Is integrated in and supports full access to the greater community to the same degree as individuals not receiving Medicaid HCBS.
b) Is selected by the individual from options including non-disability specific settings.
c) Ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint.
d) Optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices including daily activities, physical environment, and with whom to interact.
e) Facilitates individual choice regarding services and supports, and who provides them.
The plan of care is developed using person-centered practices to ensure the providers know how to support the person in an individualized fashion. The plan approval process ensures the participant and guardian signs and approves the how services will be delivered.
Action items:
 By January 31, 2016, each Participant has choice and information provided according to the new standards.
 By July 1, 2015, the state will revise the electronic plan of care to include the new standards and offer guidance on how to complete the sections using person-centered practices.
 By February 1, 2016, the case manager shall submit the revised plan of care to the Division for review and approval by March 1, 2016.

16. Milestone: By December 31, 2015, the approved ABI waiver Five Year Transition plan will be implemented and evaluated.
Action items:
- The five year transition plan for this waiver will be further implemented and evaluated for its progress. Feedback will be acquired through surveys and stakeholder meetings.
- Any substantial changes to a Transition Plan will incorporate the public notice and input process into that submission.

17. Milestone: By March 1, 2016, the state will develop and monitor a plan to address provider capacity and setting capacity if issues with capacity arise. The state must ensure that the participants served on the waivers and the number of providers and settings available are equitable.
Action items:
- By March, 1, 2016, the state will provide training and support to providers to assist with provider stability and capacity.
- By March 1, 2016, areas of the state with provider shortages will be reviewed and addressed.
- By March 1, 2018, the state will address shortage issues that may result due to the changes required in the provider setting standards.

18. Milestone: By March 1, 2016, the state will implement changes to provider monitoring practices to oversee the provider compliance to their own transition plans and milestones. CMS requires the state to ensure the provider is meeting state standards and must address areas of noncompliance through technical assistance, corrective action plans or other sanctioning actions.
Action items:
- By March 1, 2016, Provider surveying and monitoring practices by the state will be adjusted to check for compliance with the standards and the provider's action plan for transitioning.
- By March 1, 2016, the state's process for issuing corrective action will be used in areas of non-compliance found with the provider's own transition plan.

19. Milestone: Throughout 2015-16, the state will deploy a communication strategy to inform participants, guardians, providers, legislators.
Action items:
- The state will continue use multiple communication channels to get the information out about the transition plans, new standards, and any areas of concern that need attention.
- Legislators will be contacted with information on the status of the transition plan and setting progress.

Year 3 - Milestones for March 17, 2016 to March 16, 2017

20. Milestone: By March 1, 2017, providers will continue to implement transition plan and report progress to the state during recertification processes. Any business changes and policy changes should be evaluate regularly and adjusted as appropriate.
Action Items:
- By March 1, 2017, Providers will meet milestones in their transition plans and inform staff, participants and guardians regarding the changes in their programs.
- By March 1, 2017, Policies and practices will be evaluated and adjusted depending on feedback and issues that arise.
- By March 1, 2017, adjustments to provider action plans for the transition must be review by the state to ensure the changes still meet the standards.

21. Milestone: By October 31, 2016 and after the state has completed another year of site visits, monitoring and provider recertifications, if the state determines any provider settings are non-HCB, the provider will be notified that it must come into full compliance with the HCB standards by October 1, 2018. If requested by the provider, the state will determine by October 31, 2016 if the setting should be submitted to CMS for heightened scrutiny. If the state determines any provider settings are non-HCB, the provider will be notified that it must change or repurpose the setting that does not comply with the HCB standards.
Action Items:
- After the state has completed site visits, monitoring and provider recertifications during 2015 and 2016, if the state determines any provider settings are non-HCB, the provider will be notified that it must come into full compliance with the HCB standards by October 1, 2018.
- If requested by the provider, the state will determine by October 31, 2016 if the setting should be submitted to CMS for heightened scrutiny in November 2016.

Year 4 - Milestones for March 17, 2017 to March 16, 2018

22. Milestone: By December 1, 2017, the state will require a Corrective Action Plan (CAP) to be submitted within 30 days from providers if they have a setting found not in compliance. In the CAP, the provider must make final action plans regarding the changes to settings they will make to meet HCB standards or list how they will notify participants, guardians and case managers to help participants transition to new service settings by March 1, 2019.
Action Item:
- By January 1, 2018, if a providers has a service setting that does not meet the new standards, the provider will be required by the state to submit a corrective action plan within 30 days that details how they will move or repurpose a setting, or transition participants out of the setting, so that participants are not served in the setting by March 1, 2019.

23. Milestone: By March 2018, providers continue to implement transition plan and report progress to the state during recertification processes.
Action items:
- Providers meet milestones in their transition plans and inform staff, participants and guardians regarding the changes in their programs.
- Policies and practices are evaluated and adjusted depending on feedback and issues that arise.
- Adjustments to provider action plans for the transition must be review by the state to ensure the changes still meet the standards.
- Business changes and policy changes must be evaluate regularly and adjusted as appropriate.

Year 5 - Milestones for March 17, 2018 to March 16, 2019

24. Milestone: By October 1, 2018, Providers make final adjustments to meet and maintain compliance with all HCB setting standards.
Action Items:
- All provider settings must be in compliance by October 1 of year 5.
- State staff will evaluate all progress made by providers on their transition plans and address areas of non-compliance or unmet milestones and issue corrective action plans and or sanctions at the end of year five.

25. Milestone: By November 1, 2018, the waiver transition plan will receive a final evaluation by Division administrators.
Action items:
- The ABI waiver transition plan is further implemented and evaluated for its progress.

- Feedback will be acquired through surveys and stakeholder meetings.
- Any substantial changes to a Transition Plan must incorporate the public notice and input process into that submission

26. Milestone: By November 1, 2018, the state will notify providers of any setting that will be disenrolled from waiver funding due to noncompliance.

27. Milestone: By November 1, 2018, the state will issue notification to the participants and their case managers who receive services in noncompliant settings that the funding for services in those settings is discontinuing effective March 17, 2019 so the participants can be offered a choice in other providers and begin the transition process.

28. Milestone: By March 1, 2019, waiver participants must have completed the transition to new settings, if needed. By November 1, 2018, any participants (and their case managers) that are served in a setting that does not meet HCB standards will receive notice to choose another setting and possibly a new provider. If participant chooses to remain in a non-compliant setting waiver funding cannot be used.
Action items:
- Ongoing from October 2015 to December 2018, the state will meet with each provider that has a setting found to be in jeopardy of noncompliance and requiring disenrollment in 2019 to discuss all options, areas to improve, and meet with participants, guardians and stakeholders as necessary.
- Participants must begin choosing providers or new settings, having transition plans or transitioning off of the waiver if wanting to stay in a non-compliant setting. All services to participants must be in compliant settings by March 1, 2019 to ensure the state is in full compliance with CMS rules by March 16, 2019.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (1 of 8)

State Participant-Centered Service Plan Title:

Individualized Plan of Care

a. Responsibility for Service Plan Development. Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals *(select each that applies):*

- **Registered nurse, licensed to practice in the State**
- **Licensed practical or vocational nurse, acting within the scope of practice under State law**
- **Licensed physician (M.D. or D.O)**
- **Case Manager** (qualifications specified in Appendix C-1/C-3)
- **Case Manager** (qualifications not specified in Appendix C-1/C-3).

  Specify qualifications:

- **Social Worker**

  Specify qualifications:

- **Other**

  Specify the individuals and their qualifications:

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (2 of 8)

b. Service Plan Development Safeguards. *Select one:*

- **Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.**

Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.

The State has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify:*

BHD has safeguards in place to assure that the service providers' influence on the planning process (including exercising free choice of providers, controlling the content of the plan, including assessment of risk, services, frequency and duration, and informing the participant of their rights) is a part of the plan of care verification process before the plan is approved. BHD has team meeting procedures for case managers to follow to ensure choice in providers, services, institutional care, and service delivery options are reviewed with the participant and legally authorized representative annually. The provider manual & Division rules for case management also require the case manager to review choice, plan for services, risks, and one's goals without any undue influence from other providers or parties.

The Case Manager may provide any other waiver service to a participant that s/he or the agency is certified to provide when the state has demonstrated that no other willing and qualified provider is available. The state will determine if a case manager is the only option by assessing the provider list for a given area and checking with case managers in near by counties who may be able to cover the case(s). If no options are found, BHD will document the exception/conflict and revisit annually. A third party will be required and made available for any person's team if the participant and case manager do have a conflict of interest to ensure services and choice are offered fully to the participant and that the conflict is not unduly influencing the participant.

The case manager is required to fully disclose any conflicts to the participant and who they can contact if there is a concern, including the process for filing a grievance or complaint with the state in order to get BHD involvement in the case.

The provider manual & Division rules for case management also require the case manager to review choice, plan for services, risks, and one's goals without any undue influence from other providers or parties. The case manager is required to fully disclose any conflicts to the participant and who they can contact if there is a concern, including the process for filing a grievance or complaint with the state in order to get BHD involvement in the case. The state has safeguards in place to assure that the service providers' influence on the planning process (including exercising free choice of providers, controlling the content of the plan, including assessment of risk, services, frequency and duration, and informing about rights) is a part of the plan of care verification process before the plan is approved. BHD also has team meeting procedures for case managers to follow to ensure choice in providers, services, institutional care, and service delivery options are reviewed with the participant and legally authorized representative annually.

BHD requires and promotes a person-centered approach. This person-centered support begins when a person applies for the waiver by contacting BHD. BHD staff meets with the applicant or talks to them on the phone and gives applicants an Application Guide that summarizes and explains the waiver application process. Then staff walks them through the guide. During this time, staff carefully explain the application process and provide information on HCB and institutional services. This information helps ensure applicants can make an informed choice between institutional or home and community-based services. Also during this initial application review, BHD staff explain the option to self-direct services, how the applicant has choice in determining who will be his/her providers, and the process for developing and implementing a plan of care. BHD involvement from the beginning helps ensure the applicant and family understand all their options available without a provider weighing in or influencing their decisions.

The participant selects a case manager to provide targeted case management while waiting for services, and after receiving a funding opportunity the targeted case manager will help them find providers and develop the plan of care and get services approved. Before the first plan of care starts, the targeted case manager will help them look at a provider list and find providers for their plan. When the first plan is approved, this role moves to waiver case management.

The case manager also reviews the array of services available on the waiver, including the option to self-direct services.

The participant and guardian inform the case manager of the people they would like included in their circle of support that may also be on his/her team and help develop the participant's plan of care.

If self-directing, the support broker (if chosen) or the case manager helps the participant's circle of support team identify non-waiver and waiver services, which are most appropriate, available, and needed in the participant's life. If choosing traditional services, the case manager works with the participant and his/her circle of support to develop a plan of care that includes natural supports and waiver services needed to assist the person in achieving his/her personal goals.

If the person chooses to pursue HCB services, and once there is a funding opportunity, BHD staff ensures all assessments are complete and determines the IBA - not the case manager. BHD staff notifies the participant and/or guardian via mail of the funding opportunity and the participant must work with their chosen case manager to develop an plan of care and stay within the IBA assigned. When the service needs are not being met through the IBA, the case manager will help the participant through the rest of the request process.

Information in the handbook, when they initially join the waiver, and in annual information shared with the participant, they are told how to contact BHD if they need a different party involved to address or mitigate an influence.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (3 of 8)

c. Supporting the Participant in Service Plan Development. Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

BHD requires and promotes a person-centered approach to services. This person-centered support begins when a person applies for the waiver by contacting BHD. BHD staff meets with the applicant or talks to them on the phone and gives applicants an Application Guide that summarizes and explains the waiver application process. Then staff walks them through the guide. During this time, staff carefully explain the application process and provide information on home and community-based and institutional services. This information helps ensure applicants can make an informed choice between institutional or home and community-based services. Also during this initial application review, BHD staff explain the option to self-direct services, how the applicant has choice in determining who will be his/her providers, and the process for developing and implementing a plan of care.

The participant is then responsible for selecting a case manager to provide targeted case management while waiting for services, and after receiving a funding opportunity the case manager will help them find providers and develop the plan of care and get services approved.

The case manager reviews the array of services available on the waiver, including the option to self-direct services. If the participant or his/her legally authorized representative chooses to self-direct some or all their services, the case manager works with the participant to choose a support broker (optional) to assist him/her in all aspects of self-direction, unless the person can understand the information from the case manager and Division. If the participant chooses to receive traditional provider services, the case manager works with the participant to review his/her choice of providers in the community that can provide the needed services.

The participant and guardian inform the case manager of the people they would like included in their circle of support that may be on his/her team and help develop the participant's plan of care.

If self-directing, the support broker (if chosen) helps the participant's circle of support team identify non-waiver and waiver services, which are most appropriate, available, and needed in the participant's life. If choosing traditional services, the case manager works with the participant and his/her circle of support to develop a plan of care that includes natural supports and waiver services needed to assist the person in achieving his/her personal goals.

If the person chooses to pursue home and community-based services, and once there is a funding opportunity for the waiver, BHD staff ensures all assessments are complete and determines the Individual Budget Amount (IBA). BHD staff notifies the participant and/or guardian via mail of his/her funding opportunity and the participant must work with their chosen case manager to develop an individualized plan of care.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (4 of 8)

d. Service Plan Development Process. In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

Once a waiver applicant receives notification of a funding opportunity, the targeted case manager completes the risk assessment portion of the plan of care and the services needed. Once the targeted case manager submits the information to BHD in the electronic Medicaid Waiver System (EMWS), BHD reviews all assessments and determines the Individual Budget Amount (IBA) for the participant. The participant and/or legally authorized representative is notified of the IBA. The participant, legally authorized representative and the case manager reviews the array of services available on the waiver and a list of providers in the community that provide these services. The person receives a plan through targeted case management prior to waiver funded services.

The participant and legally authorized representative inform the case manager of the people they would like included in their circle of support that may be on his/her team and help develop the participant's plan of care. The participant's circle of support are family members, friends, providers, therapists, direct care staff, and other natural support people who the participant and/or guardian identifies as a network of people to assist the participant in routine life areas. The participant and/or guardian and team members inform the case manager of times they are available to meet to develop the plan of care. The case manager then schedules the meeting, notifying participant and/or legally authorized representative and the team members.

During the team meeting - the participant, case manager and team work together to develop a plan of care allocating the IBA for needed waiver and non-waiver services available and appropriate for the participant. These non-waiver services may include Medicaid State Plan Services, housing, and community services offered through grants or other programs, and natural supports.

Also during the team meeting - the case manager reviews information from the psychological evaluation, ICAP assessment, SIS, medical history, behavioral reports, and recent medical appointments or therapeutic assessments completed. This information is used throughout the plan of care to assure health, safety, risks and support needs are addressed in the plan.

The plan of care is submitted electronically through the electronic Medicaid Waiver System (EMWS). An Individualized Plan of Care eGuide and EMWS Guide were created to assist case managers in preparing, producing, modifying, and evaluating a plan of the care.

The first section completed in the EWMS plan of care begins with an "Individual Preferences". The team can use an "About Me" worksheet to help complete the information in this section. This worksheet asks questions to actively engage the participant to help develop integral components of his/her plan of care and focus on person-centered planning. These questions or others the team can asks are designed to gather input on the participant's accomplishments, progress, wishes, wants, dreams, likes, dislikes, plans for the future, etc. The case manager then enters this information gathered during the team meeting into the "Individual Preferences" section of the EMWS by detailing answers in these three comment boxes: 1) Participant's desired accomplishments for the upcoming plan year 2) Participant's personal preferences 3) Important things to know about Participant.

The second section completed in the EMWS plan of care is "Demographics". In this section, case managers provide updated demographics and current contacts information for the participant. Any communication barriers are noted in this section as well.

The third section completed in the EMWS plan of care is "Assessments". There are three assessments required in this section: LT-104, ICAP, and Psychological evaluations. These assessments are to be used to determine eligibility for the waiver and to help plan services during the team meeting.

The fourth section completed in the EMWS plan of care is "Circle of Supports". The participant's home setting is identified, his/her list of circle of supports is added, and other services being received by the participant are noted (i.e. from Department of Education, Department of Vocational Rehabilitation, etc.) Again this information is derived from the team meeting and designed to help provide a broader view of the participant's situation and needs.

The fifth section completed in the EMWS plan of care is "Needs, Risks, & Restrictions". This section covers the participant's rights, restrictions, and restoration plans for 17 support areas. If rights restrictions are imposed, the team is required to identify the reason for the restriction, how it is imposed, and how the participant can exercise their rights more fully developing and documenting a restoration plan. The team is also required to identify when the rights restrictions will be

identify the reason for the restriction, how it is imposed, and how the participant can exercise their rights while fully developing and documenting a restriction plan. The team is also required to identify when the rights restrictions will be reviewed for continued appropriateness. The maximum time frame between reviews is at least every six months, or as needed. Also if protocols are used by the provider, they are uploaded in this section with details about how best to assist the participant. The team is responsible for reviewing and documenting behaviors or conditions that pose a health and safety risk to the participant in each of the 17 support areas. Three types of restraints are noted in this section under "Other" support area: 1) Mechanical 2) Physical/Personal 3) Chemical and must be in compliance with Medicaid Chapter 45.

The sixth section completed in the EMWS plan of care is "Medical". This section includes a list of the participant's medical specialists, current medications, and any other health information pertinent to the delivery of services. It is noted in this section that the case manager must update this information in the plan of care as needed, and distribute the revised information to the team, including all providers. Examples of changes may include a change in medication.

The seventh section completed in the EMWS plan of care is "Specialized Equipment". All adaptive or specialized equipment purchased with Medicaid or public funds within the last plan year along with equipment still in use is noted in this section.

The eighth section completed in the EMWS plan of care is "Behavioral Supports". Any behavior listed on the ICAP as moderate or above requires a positive behavior support plan.

The next sections of the plan of care cover specific support needs the participant has in different settings, including at home, in the community, and at work. These sections also cover the participant's supervision needs and level of assistance needed with activities of daily living, measurable and meaningful objectives the participant has chosen to work on and behavior support needs. A Positive Behavior Support Plan is required if the individual exhibits a behavior of moderate or above on the ICAP assessment or if the team identifies any significant behavioral issues.

Throughout these sections, the plan identifies specific risks and safety plans to address the risks.

A final signature page concludes the plan of care, and all parties signing the form confirm that the plan of care has been carefully planned and coordinated with the active involvement of the participant and guardian. The signatures also assure the plan has been individually tailored, identifying appropriate waiver and non-waiver services, and establishing schedules, activities, and objectives that incorporate the participant's unique needs and preferences. The plan specifically states "I have been present, encouraged, and involved at every possible level during the development of my plan of care," therefore, by signing the plan the participant or guardian verify their involvement in the development of the plan.

The case manager is responsible for completing the initial plan of care based on the input from the participant, guardian and team. The initial plan of care must be submitted to BHD for review and approval within 45 days of receiving notification of funding. Annual plans of care for existing participants are due to the BHD for approval 30 days before the next plan start date.

Once the plan is approved by BHD, case managers have specific monitoring responsibilities to assure the plan of care is being implemented appropriately and to identify possible changes needed in the plan. These responsibilities include:

• Completing a monthly home visit with the participant present to monitor the participant's health and welfare, as well as to discuss satisfaction with both waiver and non-waiver services and needed changes to the plan of care with the participant.
• Observing the delivery of services to the participant quarterly
• Reviewing critical incidents that have occurred monthly to identify trends and concerns
• Reviewing progress on objectives monthly
• Reviewing implementation and effectiveness of the positive behavior support plan monthly
• Reviewing restraint usage and restrictive interventions monthly, following up as needed, and reporting restraint and restriction data quarterly
• Reviewing utilization of services and documentation of service delivery monthly
• Reviewing health and welfare information quarterly to identify possible changes in health status
* Review documentation and progress for all self-directed services, if applicable

If the case manager identifies concerns with either the existing plan of care meeting the needs of the participant or with the implementation of the plan of care, the case manager is responsible for working with the participant, guardian and team, including holding a team meeting, to address the concerns and revise the plan of care as needed.

In addition to the specific responsibilities listed above, the case manager is also required to coordinate a semi-annual plan of care review meeting where the participant, guardian and team formally review the effectiveness of the implementation of the plan of care and identify changes needed. The case manager is required to review specific information from implementation of the plan of care over the past six months, including a summary of progress on objectives, changes in health status, restraint and restrictive interventions occurring over the past six months, utilization of services, and other health or welfare concerns. The team identifies possible changes to the plan of care and the case manager is responsible for updating the plan based on this information.

Team members can also request a team meeting at any time to review the plan of care, request changes, or discuss concerns. If a participant is denied a service they are requesting or is denied choice of providers, they are notified of the

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (5 of 8)

e. Risk Assessment and Mitigation. Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

The individualized plan of care (IPC) developed by the participant's team must have input from the participant to determine risks and any mitigation plans. A section of the plan of care in EMWS is “Needs, Risks, & Restrictions”. This section covers the participant's rights, restrictions, and restoration plans for 17 support areas. If rights restrictions are imposed, the team is required to identify the reason for the restriction, how it is imposed, and how the participant can exercise their rights more fully developing and documenting a restoration plan. The team is also required to identify when the rights restrictions will be reviewed for continued appropriateness. The maximum time frame between reviews is at least every six months, or as needed. Also if protocols are used by the provider, they are uploaded in this section with details about how best to assist the participant. The team is responsible for reviewing and documenting behaviors or conditions that pose a health and safety risk to the participant in each of the 17 support areas. Three types of restraints are noted in this section under “Other” support area: 1) Mechanical 2) Physical/Personal 3) Chemical and must be in compliance with Medicaid Chapter 45.

"About Me" section on things the participant likes, wants in their life, and does not want in their life. Through these series of questions, the plan of care form has cues for the case manager to facilitate conversation about unhealthy habits, risky behavior, and important changes the person wants to make in their life. To further expand upon the input from the participant and guardian on risks in the "About Me" section, the BHD uses the Supports, Medical Information, and Positive Behavior Support plan sections of the IPC to address risks and construct support plans. The functional limitations, identified risks and support needs of the participant are outlined in the areas of Communication, Self-Advocacy, Transportation, specific safety supports needed, Near Water, Community Outings, Mobility, Monitoring needed during sleeping, Money transactions, Mealtime guidelines, Dietary, Emergency situations, Toileting, Personal Hygiene, Home Supervision, Positioning, and Day Site Supervision. Special protocols for any critical medical, safety, or behavioral need is expanded upon through a separate attached protocol.

For behaviors identified as potentially risky or historically risky to a person's health or safety, a carefully designed positive behavior support plan is required to mitigate risk. It is based on a functional behavior analysis of the participant's specific behaviors, antecedents, communication style and obstacles, stressors, rewards, and environmental factors. The requirements for developing and implementing a positive behavior support plan are in Chapter 45, Section 29 of the Medicaid Rules for Provider Certification. To address the need for backup plans and the arrangements used for backup, the BHD has revised the plan of care to include a section on "Backup support plans". In this section, the participant's team will review the circle of support the participant has to identify the first line of communication when the participant is in an emergency or in need of quick assistance to resolve an issue or conflict. The team will also identify who the main contact people are in the person's routine activities and environments, in case an incident arises. For individuals who live semi-independently or independently with monitoring, the plan will include a more detailed action plan for on-call or emergency situations.

In order to develop an on-call system of both natural and provider supports, the participant's team will evaluate the person's unique needs and circumstances to determine the situations that may arise where the participant may need to call someone in their "circle" for back up. These situations may include: housing issues, police involvement, money concerns, food shortages, transportation problems, witnessing criminal behavior, staff/provider problems, behavioral concerns, medical concerns and/or medical emergencies, and any other identified potential risky situations. After identifying the situations pertinent to the participant, the team will develop a contact person for the situation, and the criteria for which the situation will rise to the "on-call response" level. The backup support plan will be implemented by training all on-call contacts on the plan, teaching the participant the plan and reviewing/reteaching it as needed, posting it in a visible area for the participant, and revising it as needed. The plan will be reviewed at least every six months at the semi-annual review of the plan of care meeting, and at the annual plan of care development meeting.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (6 of 8)

f. Informed Choice of Providers. Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

ABI Waiver Waiver participants and guardians have free choice of providers and can request a change of providers, except case managers, at any time during the plan year. The BHD reviews information on provider choice when a person first applies for services on the Waiver, including the option to self-direct services and to be the employer of record or co-employer. When an applicant receives a funding opportunity, the case manager is required to review the types of services available, the list of service providers, and to emphasize the importance of choosing providers that will meet the applicant's needs. The case manager is also required to review choice of providers during each six month plan of care review meeting and before the annual plan of care meeting, so the participant has an opportunity to change providers before the new plan is developed.

The current provider list is available through the participant’s case manager and is on the BHD’s website in a searchable format so people can search for providers certified to provide a specific service in a geographic area. The individual plan of care includes a check box where the participant or guardian signs verifying they understand they have free choice of providers. BHD staff review 100% of the annual plans of care, including this section, to assure it is signed and dated. Once a participant chooses to change providers, they notify their case manager, who is required to follow a specific transition process, including scheduling a team meeting that includes the participant, guardian, other chosen team members, and both the current and future provider. This is to ensure the future provider is given all the pertinent information on the participant and the plan of care, and is involved in revisions to the plan of care as needed.

ABI Waiver participants can choose to change their case manager during the six month plan of care review process or the annual plan of care development process. This restriction to changing case managers is in place to assure there is consistent monitoring of the implementation of the plan of care and changes are made to the plan of care as needed. However, participants or guardians can request that the BHD permit a change of case manager at other times if there is a significant conflict between the participant and case manager, evidence of unethical conduct, non-performance of duties, resignation of the case manager, or other unusual circumstances. If the participant or guardian is denied the request to change, they may request a Fair Hearing. In cases where there is evidence of unethical conduct or non-performance of duties, a referral is made to the Provider Support unit within the BHD to investigate the “complaint.” If the complaint is substantiated, the case manager is required to complete a corrective action plan addressing the non-compliance with case management requirements.

The BHD maintains a listing of all providers that can be searched by town or by service type on its website. The Notice to Change Case Manager form, Transition Checklist, and listing of providers can be found on the BHD’s website http://www.health.wyo.gov/ddd. Information on participant transitions can be found in Medicaid Rule Chapter 45.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (7 of 8)

g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency. Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

The BHD is a part of the state Medicaid Agency, so it is not necessary to fill this section out.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (8 of 8)

h. Service Plan Review and Update. The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

- Every three months or more frequently when necessary
- Every six months or more frequently when necessary
- Every twelve months or more frequently when necessary
- Other schedule

Specify the other schedule:

i. Maintenance of Service Plan Forms. Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §92.42. Service plans are maintained by the following *(check each that applies):*

- [x] Medicaid agency
- [ ] Operating agency
- [x] Case manager
- [ ] Other

Specify:

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

a. Service Plan Implementation and Monitoring. Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

The first line of monitoring the implementation of the plan of care is the participant's case manager, who is responsible for completing the following monitoring activities:
• Completing a monthly home visit with the participant present to monitor the participant's health and welfare, as well as to discuss satisfaction with both waiver and non-waiver services and needed changes to the plan of care with the participant.
• Observing the delivery of services to the participant quarterly
• Reviewing critical incidents that have occurred monthly to identify trends and concerns
• Reviewing progress on objectives monthly
• Monitoring back up plans monthly
• Reviewing implementation and effectiveness of the positive behavior support plan monthly
• Reviewing restraint usage and restrictive interventions monthly, following up as needed, and reporting data quarterly to the BHD
• Reviewing utilization of services and documentation of service delivery monthly
• Reviewing status of self-directed services, including Support Brokerage services on a monthly basis, including budget utilization
• Reviewing health and welfare information quarterly to identify possible changes in health status

The case manager is required to document these monitoring activities, completing follow-up on concerns, document the follow-up actions completed, and make appropriate changes to the plan of care with team involvement when needed.

For participants self-directing services the Support Broker (if chosen) is required to assist the participant or their legal representative in assessing how services are going, in monitoring the utilization the individual budget, and is responsible for working with the participant and case manager when concerns arise. The case manager shall do this task in lieu of the support broker if not on the plan.

For participants self-directing services through the Financial Management Service - Fiscal/Employer Agent, the Division has identified flags that will identify possible concerns with utilization of services and supports so the Financial Management Service -Fiscal/Employer Agent can address the concerns. These flags include significant under-utilization of services, significant over utilization of services, purchases of goods and services over a specific dollar amount, significant concerns with hiring/firing of workers or with workers' time sheets. When these situations occur the Financial Management Service - Fiscal/Employer Agent are required to notify, as appropriate, the participant or their legal representative, the participant's case manager for follow-up, and the BHD.

The BHD is responsible for monitoring the implementation of the individual plan of care, including monitoring participant health and welfare. The unit completes this monitoring for a representative sample of participants on the Waiver combine with the populations of the other similar waivers administered by BHD (Supports, Comprehensive, Adult DD, and Child DD). The representative sample size has a 95% confidence level and a margin of error of 5%. The representative sample is identified at the beginning of year one and the review of the implementation of the plans of care is completed throughout two years, and focuses on the implementation of the entire plan of care, including non-waiver services, not just on specific providers. The review includes, when applicable and appropriate, observations of all waiver services, review of non-waiver services, review of adequacy of backup plans, interviews with the participant, provider staff, and guardians, walk through of service areas, review of case management documentation, and review of all other pertinent documentation. The focus of these reviews will be to assure participants have access to the services in their plan, that the services meet the needs of the participants, participants have access to non-waiver services in their plans, and participants' health and welfare needs are being met.

The review will also include review of case management documentation for Waiver participants for a six month period to verify the case manager is consistently monitoring the implementation of plans of care and updating the plan as needed.

In addition to reviewing the implementation of the plan of care for the representative sample, the BHD also monitors service plan implementation through the following processes:

1) Provider recertification process:
Providers are initially certified for one year and are required to complete a recertification at the end of the first year. After the initial year certification, BHD may certify an agency for up to three years depending on the service they are providing. Agencies who receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights, habilitation, or have few recommendations in other areas reviewed receive up to a one year recertification, and agencies (that don't provide residential support services or Community Integration Habilitation) who do not receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights, habilitation, or have multiple recommendations in other areas reviewed may receive up to a three year recertification, if applicable to the service being provided (as specified in Appendix C, provider qualifications).

habilitation, or have multiple recommendations in other areas reviewed may receive up to a three year recertification, if applicable to the service being provided (as specified in Appendix C - provider qualifications).

2) Incident reporting process:
BHD requires providers report specific categories of incidents as described in the incident reporting section of this application. The unit reviews each incident reported within one business day to determine if there are significant health, safety or rights concerns, including concerns with the implementation of the plan of care. These are considered level one incidents and require follow-up within ten business days. The review also includes verification the provider reported the incident to all appropriate entities and completed the appropriate follow-up actions based on the incident. If there are concerns with the incident and/or follow-up completed by the provider, BHD staff complete follow up actions to assure the concerns are addressed.

- Level 1-If the complaint is not considered a level one complaint, BHD staff complete an investigation and/or other follow-up actions to determine if the complaint is substantiated, following the timelines below:
- Level 2 – Medium Consideration: Person's health or safety is of significant concern and provider compliance needs to be ensured. This requires follow-up actions by the BHD within two weeks.
- Level 3 – Lower Consideration: Although no substantial health and safety concerns, the incident may impact the care of the person and provider compliance needs to be ensured. This requires follow-up actions by the BHD within 2 weeks-1 month.
- NAN – No Action Necessary: Adequate information and follow up have been provided. No concerns with health/safety.

3) Complaint process:
BHD manages the complaint process, described in the Grievance/Complaint section of this application. Anyone can file a complaint with any BHD staff, and the complaint is referred to the appropriate Division staff who first determines if the complaint identifies significant health, safety or rights concerns. These are considered level one complaints and require initial follow-up within two business days.

- Level 1- If the complaint is not considered a level one complaint, BHD staff complete an investigation and/or other follow-up actions to determine if the complaint is substantiated, following the timelines below:
- Level 2 – Medium Consideration. Complaint identifies potential provider non-compliance that may be impacting the quality of services participant is receiving. Investigation must be completed with 30-60 days.
- Level 3 – Lower Consideration: Complaint indicates potential provider non-compliance that does not appear to be directly impacting the quality of services to the participant. Investigation must be completed within 90 days.
- NAN – No Action Necessary: Complaint is either outside the scope of the BHD and the complainant is notified of who may have authority to investigate or the complaint does not identify any compliance issues that can be investigated.

4) Internal BHD referrals:
BHD staff can make an internal referral to the appropriate staff when they identify possible concerns with a participant's health, welfare, delivery of services, or rights. BHD staff first work with the provider to resolve these concerns, unless there are significant health or safety concerns, which results in an immediate follow-up on the concerns. BHD staff complete the appropriate follow-up actions or investigation to assure the situation is addressed appropriately.

- Level 1- Significant health or safety concerns are considered level one internal referrals and require initial follow-up within two business days. If the internal referral is not considered a level one referral, BHD staff complete an investigation and/or other follow-up actions to determine if the internal referral is substantiated, following the timelines below:
- Level 2 – Medium Consideration. Internal referral identifies potential provider non-compliance that may be impacting the quality of services participant is receiving. Investigation must be completed with 30-60 days.
- Level 3 – Lower Consideration: internal referral indicates potential provider non-compliance that does not appear to be directly impacting the quality of services to the participant. Investigation must be completed within 90 days.
- NAN – No Action Necessary: internal referral is either outside the scope of the BHD and the BHD staff is notified of the reason no action is being taken on the referral.

When significant health or safety concerns are identified through any of the above processes, BHD staff completes an initial contact with the provider within two business days to assure the immediate health and safety risks are addressed by the provider and the significant health and safety concerns have been abated. This initial contact may include an on-site visit and/or review of documentation from the provider.

If non-compliance with rules and regulations is substantiated through any of the above processes, including situations where significant health and safety concerns have been identified, the provider is required to submit a corrective action plan that includes specific action steps, responsible parties, and time frames for completing each step. If health, safety or rights concerns are substantiated the provider must submit the plan within 15 business days. All other plans must be submitted within 30 calendar days. BHD must approve the plan, and monitors the implementation of the plan to assure it has adequately addressed the area of non-compliance.

If BHD determines a participant or participants are in imminent danger, or if there is evidence of abuse or neglect, BHD can require the provider to make accommodations to protect the participant(s), up to and including moving the participant(s) to a different provider of the participant's choice. In these cases, an emergency team meeting is held and participants are provided with a list of current providers that they may choose from.

Failure to address areas of non-compliance can result in sanctioning by BHD, including suspending the provider, freezing admissions, or decertifying the provider. The BHD Provider Support unit enters and tracks information on these monitoring processes in IMPROV, BHD's provider management system. All BHD staff, the Medicaid Liaison, and Medicaid's Program Integrity Manager have role-based access to IMPROV and can view incident reports, complaints, internal referrals, as well as results of providers' recertification, so they can track the follow up on specific situations and add information as appropriate. BHD reviews data on these processes generated from IMPROV monthly and quarterly to identify significant trends that may need action before the formal annual data analysis is completed as described in Section H of this application. The Participant Support Manager and appropriate BHD staff are notified of all incidents and complaints involving Waiver participants so they are aware of what has occurred, can provide input and guidance on the follow-up actions, and can track the follow-up on the incidents and complaints through IMPROV. The Medicaid Program Integrity Manager, who reports directly to the State Medicaid Agent, is notified of all level one complaints or incidents and is involved as appropriate on identifying follow-up actions to be taken. The Medicaid Program Integrity Manager is also notified of providers who are at the point of being sanctioned, and tracks the sanctioning process to assure all appropriate steps have been taken with the provider.

b. Monitoring Safeguards. *Select one:*

- ○ **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.**
- ◉ **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant.**

The State has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify:*

BHD monitors case managers through the processes described in D-2-a. These processes include the recertification process, incident reporting process, complaint process and internal referral process.

The case manager is responsible for completing the following monitoring activities on a monthly basis: a monthly home visit, observation of services, review of documentation/billing from all service providers on the plan, review of incidents and restraints, review of progress on training objectives, review of implementation of the positive behavior support plan and crisis intervention plan, and interviews with the participant and guardian that include specific questions on satisfaction of services, identification of what is going well and what concerns exist. The case manager is required to complete a quarterly review of all of the above information to identify trends, and to respond to specific questions on whether significant changes have occurred relating to the participant's health, behavior needs, or any other significant changes. The case manager is also required to interview the participant and/or guardian to assess satisfaction with where they live, where they work, or, if they don't work, if they would like to work. The case manager is responsible for documenting these monitoring activities, completing follow-up on concerns, documenting the follow-up actions completed, and making appropriate changes to the plan of care with team involvement when needed.

The BHD reviews case management documentation to assure these monitoring activities are being completed and concerns addressed. The BHD reviews and approves 100% of plans of care developed and submitted by case managers. Part of this review and approval process is assuring the plan has been developed in the best interests of the participant and identifies appropriate services and supports based on the input from the participant, guardian and family. Participants and guardians are required to sign each plan of care verifying they agree with the services, supports in the plan and have had the opportunity to have informed choice of providers. In addition to these safeguards, the BHD has implemented policies to address specifically address conflicts of interest when case managers are providing other services on the plan.

1) The BHD has developed a process for certifying case management providers working with organizations under their own provider number. This process provides case managers with the autonomy and authority to develop the plan of care in the best interest of the participant. This process also provides the Division with the authority to sanction and, if necessary, decertify case managers who fail to serve in the best interest of the participant.

2) The BHD has enhanced its education of participants/families and guardians initially applying for services and developed a participant handbook that is distributed to all participants/families and guardians. This handbook explains the role of the case manager in assuring participants have choice of providers, the responsibilities case managers have in assuring the development of the plan of care is in the best interest of the participant and responsibilities case managers have in monitoring the implementation of the plan of care to assure it is implemented in the best interest of the participant. The handbook includes information on actions the participant and guardian can take if there are concerns with a case manager who is also providing other services on the plan of care.

3) The BHD has developed ongoing training of participants/families and guardians on the ABI Waiver, including:
- available services both in the institution and on the ABI Waiver
- using a person-centered approach to plan for services and to make changes when needed
- the purpose of a plan of care team meeting
- freedom of choice of providers including case managers
- responsibilities of case managers in developing the plan of care, monitoring implementation of the plan of care, and the conflict of interest that occurs when a case manager is providing other services on the plan of care
- participants and guardians roles and responsibilities in development of the plan of care, including participating in plan of care team meetings

Trainings are offered individually with participants when needed, regionally throughout Wyoming, and upon request.
4) A conflict of interest statement is included in the plan of care that summarizes how conflict will be addressed, how the best interest of the participant is assured, how monitoring will be enhanced, and what actions the participant/guardian should take if he or she has concerns with any aspects of the case manager's roles and responsibilities. BHD staff serve as a resource to case managers' and the participants' teams to educate them on conflicts of interest, and the responsibilities the case manager has in choice, development of the plan of care, and monitoring implementation of the plan of care.

5) BHD requires agencies providing case management, case managers employed by agencies, and self-employed case managers providing other services on plans of care to develop and implement a comprehensive conflict of interest policy that addresses the areas of choice, development of the plan of care and implementation of the plan of care.

6) BHD requires comprehensive case management policies on how agency or self-employed case manager will follow up and provide feedback on concerns identified during development or monitoring of plan of care.

7) BHD has developed a web-based complaint process so participants, guardians and families can file a complaint easily with the BHD if they have concerns. The web-based system provides another avenue for participants, families and guardians to file a complaint at any time as long as they have access to the Internet. BHD continues to review 100% of annual plans of care. The review and approval process for plans of care includes a review of the conflict of interest information required in the plan to assure that conflicts of interest are adequately identified and addressed in the plan.

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Service Plan Assurance/Sub-assurances

The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

i. Sub-Assurances:

a. ***Sub-assurance: Service plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis*(check each that applies):*

17 Percentage of Waiver Plans of Care in which the individual's assessed needs align with the services and supports (the number of plans in which the individual's assessed needs align with the services and supports divided by the total of plans reviewed)

Data Source (Select one):
Other
If 'Other' is selected, specify:
Electronic Medicaid Waiver System

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
18 Percentage of Waiver Plans of Care in which identified risks align with appropriate supports and accommodations (the number of plans in which identified risks align with appropriate supports and accommodations divided by the total number of plans reviewed)

Data Source (Select one):
Other
If 'Other' is selected, specify:
Electronic Medicaid Waiver System

Responsible Party for data collection/generation*(check*	**Frequency of data collection/generation***(check each that*	**Sampling Approach***(check each that applies):*

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis *(check each that applies):*	
☑ State Medicaid Agency	☐ Weekly	☑ 100% Review
☐ Operating Agency	☐ Monthly	☐ Less than 100% Review
☐ Sub-State Entity	☑ Quarterly	☐ Representative Sample Confidence Interval =
☐ Other Specify:	☐ Annually	☐ Stratified Describe Group:
	☐ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis *(check each that applies):*
☑ State Medicaid Agency	☐ Weekly
☐ Operating Agency	☐ Monthly
☐ Sub-State Entity	☐ Quarterly
☐ Other Specify:	☑ Annually
	☐ Continuously and Ongoing
	☐ Other Specify:

Performance Measure:
19 Percentage of Waiver Plans of Care that reflect the individual's personal goals (the number of plans that reflect the individual's personal goals divided by the total number of plans reviewed)

Data Source (Select one):
Other
If 'Other' is selected, specify:
Electronic Medicaid Waiver System

Responsible Party for data collection/generation *(check each that applies):*	Frequency of data collection/generation *(check each that applies):*	Sampling Approach *(check each that applies):*
☑ State Medicaid Agency	☐ Weekly	☑ 100% Review
☐ Operating Agency	☐ Monthly	☐ Less than 100% Review
☐ Sub-State Entity	☑ Quarterly	☐ Representative Sample Confidence Interval =

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis *(check each that applies):*	
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
20 Percentage of Waiver Plans of Care with participant and/or guardian signature verifying they participated in the development of the plan (the number of plans with signature affixed divided by the number of plans reviewed)

Data Source (Select one):
Other
If 'Other' is selected, specify:
Electronic Medicaid Waiver System (EMWS)

Responsible Party for data collection/generation *(check each that applies):*	Frequency of data collection/generation *(check each that applies):*	Sampling Approach *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis*(check each that applies):*
☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis*(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: The State monitors service plan development in accordance with its policies and procedures.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
21 Percentage of Individualized Plans of Care (IPC) that meet program requirements before approval (numerator is the number of IPCs that meet program requirements before approval divided by the number of IPCs approved)

Data Source (Select one):
Other
If 'Other' is selected, specify:
EMWS

Responsible Party for data collection/generation*(check each that applies):*	Frequency of data collection/generation*(check each that applies):*	Sampling Approach*(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:

Responsible Party for data aggregation and analysis *(check each that applies):*	Continuously and Ongoing	Frequency of data aggregation and analysis *(check each that applies):*	Other
			Specify:
	Other Specify:		

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis *(check each that applies):*
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify:	Annually
	Continuously and Ongoing
	Other Specify:

c. ***Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participant's needs.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
22 Percentage of Individualized Plans of Care (IPC) and modifications to plans of care that meet program requirements before approval (the number of IPCs and modifications to IPCs that meet program requirements before approval divided by the number of IPCs and modifications approved)

Data Source (Select one):
Other
If 'Other' is selected, specify:
EMWS

Responsible Party for data collection/generation *(check each that applies):*	Frequency of data collection/generation *(check each that applies):*	Sampling Approach *(check each that applies):*
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval =
Other Specify:	Annually	Stratified Describe Group:

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis*(check each that applies):*	
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis*(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

d. ***Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
23 Percentage of Waiver Plans of Care in which services and supports are provided in the type, scope, amount, duration, and frequency specified in the plan (the number of plans in which services and supports are provided in the type, scope, amount, duration, and frequency specified in the plan divided by the total number of plans reviewed)

Data Source (Select one):
On-site observations, interviews, monitoring
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	Frequency of data collection/generation*(check each that applies):*	Sampling Approach*(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95% +/- 5%
☐ **Other**	☑ **Annually**	☐ **Stratified**

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis *(check each that applies):*	
Specify:		Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: Sampling size is combined with the Wyoming Supports, and Acquired Brain Injury waiver.
	☑ **Other** Specify: Interviews are completed over a two year period to obtain a representative sample. A preliminary report is compiled in the first year so significant trends can be identified.	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

e. ***Sub-assurance: Participants are afforded choice: Between waiver services and institutional care; and between/among waiver services and providers.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
24 Percentage of Waiver participants or guardians who verify by signature on the annual plan of care stating they were given choice of providers, institutional care, and services (the number of verified choice in the plan of care documentation divided by the number of plans approved)

Data Source (Select one):
Other
If 'Other' is selected, specify:
EMWS

Responsible Party for data collection/generation *(check each that applies):*	Frequency of data collection/generation *(check each that applies):*	Sampling Approach *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*	Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

Sub-Assurance a & b:

Responsible Party *(check each that applies):* **Frequency of data aggregation and analysis** *(check each that applies):*

BHD staff review 100% of plans of care, following detailed plan of care instructions that are available to all providers on the Division's website. The plan of care includes sections on health and safety risk assessments, safety plans to address risks, personal goals, non-waiver services, medical information, behavior plans, and other supports needed either by the provision of waiver service's or through other means. The BHD's review and approval process includes verification that the plan adequately addresses these areas, the participant and guardian actively participated in the development of the plan, and the plan was developed in accordance with state policy and procedures. The case manager is required to correct incomplete or incorrect sections of the plan of care before receiving BHD approval. BHD staff tracks incomplete or incorrect sections of the plan in EMWS, and this data is reviewed quarterly and analyzed for trends.

Sub-Assurance c:
The BHD requires in rule that all plans of care are:
• Approved annually by the BHD,
• Updated as warranted by changes in the participant's needs

Changes to the plan of care primarily occur through the team meeting process and case managers are required to maintain team meeting notes for each meeting. If a change is requested by the participant, guardian or other team member at a time other than at the annual or semi-annual review, a team meeting must be held to discuss the change. If the change is agreed upon, the case manager modifies the plan of care, and when required, submits the modification to BHD in EMWS. BHD conducts case management record reviews during the provider recertification process. If it is discovered that the participant did not have a semi-annual review meeting or a team meeting as needed for a specific change in the plan, it will be noted in the recertification report and a Corrective action plan will be required.

Case managers are required to complete a review of the implementation of the service plan monthly, and a more in depth review quarterly, to ensure a participants needs, wants, health, safety, and satisfaction with services are being assessed for possible service plan changes. Record review of the case manager's monthly and quarterly case notes are performed during the recertification process or as warranted by incident reports or complaints. If the case manager is not meeting the monitoring and documentation requirements they must submit a Corrective action plan to address the identified concerns. BHD keeps track of participants' plans that are due each month to assure plans are updated annually. If a plan is not submitted on time, the case manager is notified within two days to inquire about the tardiness of the plan submission and work with the case manager on a deadline for submission. Late plan submission by a case manager is noted in the person's provider file, and if the problem continues, it is a certification issue with the provider, which requires a Corrective action plan. The date the plan is approved is noted by the BHD in a plan of care spreadsheet and in the waiver access database. If a lapse in services occurs due to the delayed start date, then the BHD works with the case manager to assure the health and safety of the participant until the plan is approved and services can be reimbursed.

Sub-Assurance d:
The BHD assesses the implementation of plans of care by completing a thorough assessment of services received by a representative sample of waiver participants. This review includes a review of provider documentation of services, observations of service delivery to assure it meets the requirements in the plan of care, review of utilization and claims for services, and provider compliance with the state rules and standards. Information on the results of the monitoring is tracked in IMPROV, including specific concerns that must be addressed by the case manager and/or provider. If a deficit is discovered, then a corrective action plan is required by the provider to address the area of non-compliance.

Sub-Assurance e:
Case managers are required to offer choice of providers, choice of waiver services and choice of institutional care to the participant and/or guardian at the time of the annual plan of care and semi-annual review, and more frequently by request of the participant or legally authorized representative. The plan of care includes a section where the guardian and/or participant verify that they have reviewed their choices through a provider list,have reviewed the waiver services available, and they know they have a choice between home and community based services and the Wyoming Life Resource Center (the state ICF/IID). BHD tracks when and if choice was offered and discussed prior to or during the annual plan of care development meeting using EMWS.

The state monitors this sub-assurance through participant and guardian interviews during the recertification process with providers and the representative sample case review. If it is discovered that the participant did not receive the opportunity to choose providers as requested or at a six month review or annual team meeting, the concern will result in a corrective action plan by the provider to address this area of non-compliance.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Service Plans that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Service Plans, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix E: Participant Direction of Services

Applicability *(from Application Section 3, Components of the Waiver Request)*:

- (●) **Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.
- ( ) **No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.

Indicate whether Independence Plus designation is requested *(select one):*

- ( ) **Yes. The State requests that this waiver be considered for Independence Plus designation.**
- (●) **No. Independence Plus designation is not requested.**

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

a. Description of Participant Direction. In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the waiver's approach to participant direction.

ABI Waiver participants are given the opportunity to receive:
1) Support services provided by qualified Home and Community Based Medicaid Waiver providers certified by the BHD,
2) The option to self-direct their services, or
3) Both.

If self-directing one or more of their services, participants can act as the employer of record with the Fiscal/Employer Agent - Financial Management Service (FMS). This option gives participants the authority and responsibility to recruit, hire, schedule, evaluate and supervise their workers and gives the participant budgetary authority.

Participants choosing to be the employer of record and work with the Fiscal/Employer Agent-FMS may choose to have budgetary authority. In addition to receiving support from the Fiscal/Employer Agent-FMS, participants self-directing their services receive assistance as needed with the employer activities through a Support Broker, chosen by the participant.

Support Brokerage is an optional service for a participant or legally authorized representative who self-directs services. If an EOR is struggling with self-directing responsibilities, the Division may require a Support Broker to be added to the personâ€™s plan of care in order to continue to self-direct. After a year of required support brokerage, the participant or representative may opt out of support broker services if he/she meets one of the criteria below and submits a formal request to opt out of Support Broker Services.

Criteria for Opting Out of Support Broker Services includes the following, which is captured on an assessment tool completed by the case manager and approved by the Division:
1. Participants or their legal representatives who are self-directing through the Financial Management Service who demonstrate the ability to choose workers, coordinate the hiring of workers through the Financial Management Service provider, and coordinate the delivery of services with the FMS provider.
2. Participants or their legal representatives who have successfully self-directed services for one year with no concerns, including hiring, firing, training, scheduling workers and reviewing timesheets in a timely manner.

Concerns may include having compliance issues with fulfilling co-employer duties, utilizing services and budget inappropriately, having incidents that require more frequent monitoring from the case manager and/or BHD to ensure safety.

BHD has a self-direction handbook that provides information to participants on self-direction. BHD staff review this handbook with applicants when they apply for the waiver, and the participant's case manager reviews this information when a funding letter is received so the participant or their representative can determine if they want to self-direct some or all of their services. BHD has basic training modules on self-direction, and participants or their legal representatives interested in self-directing services have the opportunity take a self-direction online mondule, attend a training in person or by viewing a DVD to review this information. BHD staff located throughout the state serve as ongoing resources if questions or concerns arise about self-directing services.

If participants or their legal representatives choose to self-direct one or more services, they work with their case manager to choose a Support Broker in their geographic area who is certified by the BHD, who can assist them with the self-direction process. Participants or their legal representatives can also choose to self-direct the Support Broker service as the common law employer and employ a Support Broker. This option is included to allow participants to choose a person well known to them who can provide Support Brokerage services but who does not meet the minimum requirements to be certified as a Support Broker provider through the BHD. The person chosen by the participant can only serve as a Support Broker for that participant and must complete the same training as certified Support Brokers (described below). Support Brokers are required to complete comprehensive training on self-direction and pass a competency based test. The training includes:
1) Principles of self-determination
2) What self-directing services means
3) The roles and responsibilities of the Support Broker, Financial Management Service - Fiscal/Employer Agent, and the Case Manager
4) What the participant and Support Broker need to know about hiring and firing staff

The ABI Waiver includes the following services and supports to assist participants in self-direction:
1) A Financial Management Service provider serving as Fiscal/Employer Agent, which is funded as an administrative activity and does not come out of a participant's budget. The Fiscal/Employer Agent-FMS assures all Federal, state and local employment tax, labor and workersâ€™ compensation insurance rules and other requirements are followed when the participant functions as the employer of workers. The Fiscal/Employer Agent-FMS makes financial transactions on behalf of participants who have chosen to have budgetary authority.
2) A Support Broker - a waiver service that assists a participant in self-directing services, including assisting them in finding staff, hiring and firing of staff while adhering to labor laws, managing the budget, reviewing and authorizing time sheets, and changing the plan of care when needed.
3) Case Management - a waiver service that develops and submits the plan of care to BHD, working with the participant self-directing and their Circle of Support, monitors the implementation of the plan of care, completes follow-up on concerns found with implementation of the plan.

All 3 of these services/supports have responsibility to provide protection and safeguards to participants self-directing services. The Fiscal/Employer Agent-FMS assures all IRS and other applicable employer requirements are met, assures workers chosen by participants meet all state requirements before services are provided, tracks budget utilization and purchases funded through Goods and Services to assure funds are being used appropriately, and reports concerns to case managers and the BHD as required. The Support Broker assures the participant is following federal, state and local laws when hiring and firing staff, is monitoring the use of the budget and has planned for the entire plan year, and works with the participant and case manager when concerns arise. The Case Manager develops and monitors the implementation of the plan of care, including self-directed services, to assure health and welfare needs identified in the plan are met and risks are clearly identified and addressed.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

b. Participant Direction Opportunities. Specify the participant direction opportunities that are available in the waiver. *Select one*:

- ○ **Participant: Employer Authority.** As specified in ***Appendix E-2, Item a***, the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.
- ○ **Participant: Budget Authority.** As specified in ***Appendix E-2, Item b***, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.
- ◉ **Both Authorities.** The waiver provides for both participant direction opportunities as specified in ***Appendix E-2***. Supports and protections are available for participants who exercise these authorities.

c. Availability of Participant Direction by Type of Living Arrangement. *Check each that applies*:

- [x] **Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.**
- [x] **Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.**
- [ ] **The participant direction opportunities are available to persons in the following other living arrangements**

Specify these living arrangements:

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

d. Election of Participant Direction. Election of participant direction is subject to the following policy *(select one):*

- ( ) **Waiver is designed to support only individuals who want to direct their services.**
- (•) **The waiver is designed to afford every participant (or the participant's representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.**
- ( ) **The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the State. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria.**

Specify the criteria

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

e. Information Furnished to Participant. Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

BHD has a self-direction handbook that provides a simple summary of self-directing services. The handbook includes:
1) An overview of self-determination and self-directing services, including the principles of self-determination (Freedom, Authority, Support, Responsibility, and Confirmation).
2) The benefits of self-directing, including more choice and control over services and how the budget is spent.
3) The responsibilities involved in self-directing services, including hiring and firing workers, managing the budget, approving workers' timecards.
4) The potential liabilities of self-directing services, including liabilities that may occur as the common law employer when hiring or firing staff, managing the budget, and approving timecards.
5) Services/supports on the ABI Waiver that can assist them in self-directing, including the Support Broker and Case Manager.
6) A basic assessment that will help the participant or their legal representative determine if self-directing is appropriate for them.
7) Further resources that may be helpful to participants who are considering whether or not to self-direct services, including local/state resources.

BHD staff review the handbook with applicants who are applying for the ABI Waiver. When funding becomes available, the participant's case manager again review the handbook and discuss the options for self-directing services on the waiver. For existing Waiver participants, the case manager provides information on self-direction twice a year during home visits or team meetings, and at any time a participant expresses an interest in self-directing services. In addition to the handbook, BHD has an online training module on self-direction so participants or their legal representatives interested in self-directing services have the opportunity to learn about it from the Division. BHD staff located throughout the state serve as ongoing resources as questions or concerns arise about self-directing services.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

f. Participant Direction by a Representative. Specify the State's policy concerning the direction of waiver services by a representative *(select one):*

- ( ) **The State does not provide for the direction of waiver services by a representative.**
- (•) **The State provides for the direction of waiver services by representatives.**

Specify the representatives who may direct waiver services: *(check each that applies)*:

- [x] **Waiver services may be directed by a legal representative of the participant.**
- [ ] **Waiver services may be directed by a non-legal representative freely chosen by an adult participant.**

Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

Waiver Service	Employer Authority	Budget Authority

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

g. Participant-Directed Services. Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-1/C-3.

Waiver Service	Employer Authority	Budget Authority
Personal Care	☑	☑
Companion Services	☑	☑
Independent Support Broker	☑	☑
Residential Habilitation	☑	☑
Homemaker	☑	☑
Supported Living	☑	☑
Respite	☑	☑
Supported Employment	☑	☑
Self-Directed Goods and Services	☑	☑

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

h. Financial Management Services. Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. *Select one*:

◉ **Yes. Financial Management Services are furnished through a third party entity.** *(Complete item E-1-i).*

Specify whether governmental and/or private entities furnish these services. *Check each that applies*:

☐ **Governmental entities**
☑ **Private entities**

○ **No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used.** *Do not complete Item E-1-i.*

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

i. Provision of Financial Management Services. Financial management services (FMS) may be furnished as a waiver service or as an administrative activity. *Select one*:

○ **FMS are covered as the waiver service specified in Appendix C-1/C-3**

The waiver service entitled:

◉ **FMS are provided as an administrative activity.**

Provide the following information

i. Types of Entities: Specify the types of entities that furnish FMS and the method of procuring these services:

Every three years the BHD undergoes a Request for Proposal (RFP) of any Financial Management entities that might be interested in contracting out for Financial Management Services (FMS). Those entities that are submitting an RFP include a PMPM rate. The BHD then determines who will be granted the contract for FMS. The contract includes the PMPM rate that will be paid to the FMS. BHD has a contractor to provide Financial Management Services under the Fiscal/Employer Agent Model, which was procured through a request for proposal (RFP). The FMS/FEA who was awarded the contract was one of three private companies that submitted a proposal to the Division for consideration. The state procuring processes were utilized to issue the RFP and score the submitted proposals in order to determine the company who would be hired through contract.

ii. Payment for FMS. Specify how FMS entities are compensated for the administrative activities that they perform:

The Fiscal/Employer Agent - Financial Management Service is compensated by the BHD for administrative activities based upon a per-member-per-month (PMPM) reimbursement method.

iii. Scope of FMS. Specify the scope of the supports that FMS entities provide *(check each that applies)*:

Supports furnished when the participant is the employer of direct support workers:

- [x] **Assist participant in verifying support worker citizenship status**
- [x] **Collect and process timesheets of support workers**
- [x] **Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance**
- [ ] **Other**

Specify:

Supports furnished when the participant exercises budget authority:

- [x] **Maintain a separate account for each participant's participant-directed budget**
- [x] **Track and report participant funds, disbursements and the balance of participant funds**
- [x] **Process and pay invoices for goods and services approved in the service plan**
- [x] **Provide participant with periodic reports of expenditures and the status of the participant-directed budget**
- [ ] **Other services and supports**

Specify:

Additional functions/activities:

- [x] **Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency**
- [x] **Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency**
- [x] **Provide other entities specified by the State with periodic reports of expenditures and the status of the participant-directed budget**
- [ ] **Other**

Specify:

iv. Oversight of FMS Entities. Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.

State Medicaid Agency and BHD Policy for Monitoring the Fiscal/Employer Agent Financial Management Service:

The Vendor Fiscal/Employer Agent Financial Management Service is monitored to assure the Agent is adhering to Federal, State and BHD regulations and standards. The monitoring process includes monthly monitoring by case managers, monthly status meetings, an biannual review completed jointly by BHD and the Medicaid Program Integrity Unit, and ongoing monitoring through the BHD's complaint process and incident reporting process.

Policy Provisions:
BHD issues policy, procedure manuals, memorandums, instructions and other BHD correspondence to interpret and implement the approved waivers, including information on the roles and responsibilities of the Fiscal/Employer Agent Financial Management Service, responsibilities of the case manager in the monthly monitoring of services provided by the Agent, and monitoring responsibilities of the BHD and the Medicaid Program Integrity Unit.

The BHD in conjunction with the Medicaid Program Integrity Unit completes an biennual review of the Fiscal/Employer Agent Financial Management Service for a representative sample of participants utilizing this service. The representative sample has a confidence interval of 95% +/- 5% error rate. The biennual review of the representative sample completed by the BHD includes a review of the following components:

• A review of participant files to verify the file has the following:
  o A completed enrollment application for the participant that contains all required forms and information
  o A federal employer identification number (FEIN) for the participant and copies of the participant's FEIN
  o IRS FEIN notification and the filed Form SS-4, Application for Employer Identification Number in the participant's file
  o A signed IRS Form 2678: Employer/Payer Appointment of Agent for the participant and documentation (copy of IRS Form 2678, Request for Approval Letter and IRS Notification of F/EA Approval) on file
  o Written authorization from the IRS to be the Agent for the participant and a copy of the written authorization in the participant's file
  o A copy of a current signed IRS Form 8821, Tax Information Authorization for the participant in the participant's file
  o Obtained a state power of attorney (for state income tax, unemployment tax or both, as required by the state) from the participant it represents, maintained in the participant's file

• A review of participant workers' files to verify the file has the following:
o A completed employment packet for participant's employees that contain all required forms and information, including completed employment application, IRS Form W-4, state Form W-4, if applicable, (USCIS Form I-9, IRS Notice 797)
o Completed background checks, current CPR, current First Aid, and verification of required training
o Collected and processed an IRS Form W-4 from each worker it processes payroll and for maintaining a copy of the form in each worker's file
o Verification of worker's citizenship and alien status by collecting and maintaining a completed US CIS Form I-9, Employment Eligibility Verification for every worker it processes payroll for in each worker's file
o Verification of each worker's social security number and maintained the appropriate documentation in each worker's file
o Verification of the state of residence for each worker and maintained the appropriate documentation in each worker's file
o Having paid workers in compliance with federal and state Department of Labor wage and hour rules for regular and overtime pay
o Verification of and processing of workers' timesheets and copies maintained in the workers' files
o Documentation of the withholding of FICA (Medicare and social security taxes) and federal income tax for each worker per payroll period including the employer's contribution.

The biennial review of the representative sample completed by the Medicaid Program Integrity Unit includes a review of the following components:
• A review of claims paid to the Fiscal/Employer Agent Financial Management Service for services received by participants in the representative sample, and corresponding paychecks paid to employees of the participants in the representative sample to assure the documentation supports the billing and payment for services
• A review of the timesheets and documentation of services to assure employees of participants are adhering to the current documentation standards for services
• A review of the per member per month payments to the Fiscal/Employer Agent Financial Management Service to assure payments are accurate

The BHD monitors call center reports from the Agent monthlyly. The reports are reviewed for timeliness of response, numbers of calls received, and other trends relating to call data. The BHD completes a review of the Agent's contract biennially or as needed if concerns arise.

BHD and the Medicaid Program Integrity Unit jointly completes a biennial review of the Fiscal/Employer Agent business practices to verify all required IRS regulations, as well as state unemployment and worker's compensation regulations are being adhered. BHD receives a copy of the Agent's independent audits annually. BHD conducts customer satisfaction interviews with participants chosen in the representative sample. The interviews are conducted with both the common law employer (participant or their legal representative) and employees to assess the satisfaction of Fiscal/Employer Agent Financial Management Service, including timely processing of timesheets, timely resolution to customer service calls and assistance in completing enrollment packets.

The BHD conducts an annual review of the Agent's complaint policy and complaints filed to ensure:
• Adequate written information is conveyed to the participant and or their legal representative, and to employees of the participant regarding how to file a formal complaint with the Fiscal/Employer Agent Financial Management Service.
• All complaints are reviewed in a timely manner and addressed appropriately to all parties concerned.
• Any complaints found that were not reviewed in a timely manner according to the Agent's policy or that were left unresolved will result in the Fiscal/Employer Agent Financial Management Service completing a Corrective action plan, as specified in the Remediation section.

Procedures:
• BHD and the Medicaid Program Integrity Unit select the participants for the representative sample at the start of two year cycle. The representative sample of files to be reviewed have a 95% confidence interval and a +-5% margin of error rate and be selected by the BHD. The review is conducted over two years.
• BHD maintains the findings of the file reviews and track the follow up of concerns identified through a database. If the Medicaid Program Integrity Unit identifies a concern with claims, the unit follows up as listed in the remediation section of this policy and reports the status of an investigation or recovery with BHD. At the end of the two year cycle, a final report of the findings and follow up conducted during the two years is compiled within sixty days of the end of the 2nd Fiscal Year. The report is distributed to the Fiscal/Employer Agent Financial Management Service, the BHD Administration, and the Medicaid Program Integrity Unit.
• BHD and the Medicaid Program Integrity Unit shall review the participant and worker file reviews and Agent Review report with the Medicaid State Agent and any findings will be followed up in the process listed in the Remediation section of this policy.
• BHD conducts satisfaction interviews with participants and providers using the Agent's services and compile a report for review by Medicaid. Any concerns found are followed up in the process listed in the Remediation section of this policy.
• BHD reviews the Agent's business practices and complaint process to ensure the Agent is in compliance with BHD rules, the Agent's contract, and the Agent's own written policies and business rules.

Remediation:
The Fiscal/Employer Agent Financial Management Service is required to address any concerns found within a specified time period designated by BHD, and, when applicable, to pay corresponding penalties and fees. These concerns include the following:
• Missing documents in the participant file
• Missing documents in the participant's worker's file
• Problems with implementation or compliance with the Agent's contract
• Compliance or problems found with the Agent's business practices
• Issues noted in customer satisfaction interviews
• Unresolved complaints
• Unreported Incidents or flags on participants cases

The Agent's contract includes clauses for termination of the contract if serious concerns are identified. The Fiscal/Employer Agent Financial Management Service shall submit a corrective action plan within the requirements of Wyoming Medicaid Rules, Chapter 45 for each area of non-compliance identified in the participant file review report within thirty days of receipt of the report. BHD and the Medicaid Program Integrity Unit reviews and approves the corrective action plan according to the Wyoming Medicaid Rules, Chapter 45 and monitors implementation of the corrective action plan to assure areas of non-compliance are adequately addressed.

The Medicaid Program Integrity Unit completes the recovery of funds if documentation of services does not support the billing and payment for services. The Medicaid Program Integrity unit completes the required process to assure the Centers of Medicare and Medicaid Services (CMS) is reimbursed for the federal portions of payments when recovery of funds occurs.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

j. Information and Assistance in Support of Participant Direction. In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested *(check each that applies)*:

☑ **Case Management Activity.** Information and assistance in support of participant direction are furnished as an element of Medicaid case management services.

Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:

BHD provides information on traditional service delivery and self-direction when they meet with applicants.

Case managers provide information on self-direction and assistance in support of self-direction when a person on the wait list receives a funding letter for the Waiver, and twice a year or as needed for existing waiver participants through home visits or team meetings.

The information provided by the case manager includes a review of the BHD self-direction handbook, and a review of the Self-Direction self-assessment tool. The handbook includes:
1) An overview of self-determination and self-directing services, including the principles of self-determination (Freedom, Authority, Support, Responsibility, and Confirmation)
2) The benefits of self-directing, including more choice and control over services and how the budget is spent
3) The responsibilities involved in self-directing services, including hiring and firing workers, managing the budget, approving workers' timecards
4) The potential liabilities of self-directing services, including liabilities that may occur as the employer of record when hiring or firing staff, managing the budget, and approving timecards.
5) Services/supports on the Supports Waiver that can assist them in self-directing services, including the Support Broker, Financial Management Service - Fiscal/Employer Agent Provider, and Case Manager.
6) A basic assessment that will help the participant or their legal representative determine if self-directing is appropriate for them.
7) Further resources that may be helpful to participants who are considering whether or not to self-direct services, including local/state resources.

If a participant or their legal representative chooses to self-direct services, the case manager reviews the important role that the Support Broker has in assisting the participant in self-direction, although a support broker is optional unless required by BHD. The case manager provides the participant with a list of Support Brokers in their geographic area, and works with the participant, Support Broker, and Circle of Support to develop a plan of care that identifies non-waiver and waiver supports and services needed by the participant. If a Support Broker is not available, or the team has decided not to utilize the services of a Support Broker, the Case Manager assists the team if needed or requested.

☑ **Waiver Service Coverage.** Information and assistance in support of participant direction are provided through the following waiver service coverage(s) specified in Appendix C-1/C-3 (check each that applies):

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Speech, Hearing and Language Services	☐
Prevocational Services	☐
Crisis Intervention Support	☐
Personal Care	☐
Cognitive Retraining	☐
Companion Services	☐
Independent Support Broker	☑
Residential Habilitation	☐
Adult Day Services	☐
Homemaker	☐
Supported Living	☐
Skilled Nursing	☐
Case Management	☑
Community Integration Services	☐
Respite	☐
Transportation	☐
Supported Employment	☐
Behavioral Support Services	☐
Specialized Equipment	☐
Self-Directed Goods and Services	☐
Occupational Therapy	☐
Dietician Services	☐
Environmental Modifications	☐

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Physical Therapy	☐

☑ **Administrative Activity.** Information and assistance in support of participant direction are furnished as an administrative activity.

Specify (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:

The Fiscal/Employer Agent-Financial Management Service provider gives information and assistance in support of self-direction specific to participants serving as employer of record. This assistance may be in the form of reviewing employer responsibilities with participants or their legal representatives, including accurate review of timecards, managing the budget and assuring workers submit required paperwork, both initially and ongoing.

BHD and the Program Integrity Unit of the Division of Healthcare Financing has processes for assessing the performance of the Fiscal/Employer Agent FMS. This process includes both auditing processes to assure the FMS is performing duties per IRS, federal, and state rules and regulations, satisfaction surveys of participants receiving FMS services from the vendor, and assessment of information and education provided by the FMS to participants.

Oversight of Vendor Fiscal Employer Agent Financial Management Service:
The state has developed a tiered approach to monitoring the performance of the Vendor Fiscal/Employer Agent Financial Management Service, including oversight by the case manager, BHD, and Medicaid's Program Integrity Unit.

The case manager reviews the performance of the Vendor Fiscal Employer Agent Financial Management service during the required monthly home visit with the participant. The case manager is required to document the specific concerns, complete and document follow-up actions to address the concerns, and assure the concerns are resolved. Follow-up includes, as appropriate:
• Direct contact with the Fiscal Employer Agent Financial Management Service informing them of concerns and working with them to resolve the issues.
• Meeting with appropriate parties involved, including the Support Broker, employee of participant who is involved in situation, and Vendor Fiscal Employer Agent Financial Management Service representative, to work through the concerns.
• Reporting issues to the BHD if significant concerns are identified that impact health and safety, indicate potentially fraudulent activity, and/or if concerns are not addressed by Vendor Fiscal Employer Agent Financial Management after the case manager has worked directly with them.

The BHD monitors the Vendor Fiscal Employer Agent Financial Management Service through the following processes:
• Monitoring the Vendor Fiscal Employer Agent Financial Management monthly budget utilization reports for all participants self-directing services to assure reports are accurately reflecting service utilization, reviewing flagged participants who are over utilizing or under utilizing their budgets, and business rules are adhered to, including rules on service limitations.
• Completing a biennual review of Vendor Fiscal Employer Agent Financial Management Services for a representative sample of individuals utilizing this service. The representative sample has a confidence interval of 95% +/- 5% error

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

k. Independent Advocacy *(select one).*

◉ **No. Arrangements have not been made for independent advocacy.**

○ **Yes. Independent advocacy is available to participants who direct their services.**

Describe the nature of this independent advocacy and how participants may access this advocacy:

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

l. Voluntary Termination of Participant Direction. Describe how the State accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the State assures continuity of services and participant health and welfare during the transition from participant direction:

A participant may voluntarily terminate self-direction at anytime during their plan year. When a participant voluntarily terminates self-direction the participant works with the case manager who follows the BHD transition process for changing services and/or service providers. Voluntary termination of self-direction does not require that the participant change waivers, since traditional provider-based waiver services are available on the Waiver as well as self-directed services.

The transition process includes a transition team meeting to assure the team, including all providers, have current information on the changes being made to the plan of care. During the transition team meeting the case manager revises the plan of care to reflect the changes in services and service providers. The plan of care is submitted to the BHD for approval before the transitions occur. The BHD has seven calendar days to review and approve the revised plan of care.

The case manager works with the participant or their legal representative to notify the appropriate Financial Management Service provider of the termination of self-directed services and assists the participant in completing any required paperwork.

BHD also has an emergency transition process in place if there are significant health and welfare concerns that may require a quicker transition out of self-directed services. This transition process requires that BHD staff are involved in the transition process so the BHD can assure the new services and service providers meet the needs of the participant and to assure the participant's health and welfare needs are met during the transition from self-direction. The case manager submits the revised plan of care to BHD, which can approve the revised plan within one business day if an emergency situation exists. Once a participant has chosen to voluntarily terminate self-direction, they cannot choose to self-direct services until their semi-annual or annual plan of care meeting, which will assure that the participant and team has an opportunity to plan the transition back to self-directed services carefully.

Appendix E: Participant Direction of Services

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	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	Number of Participants	Number of Participants

m. Involuntary Termination of Participant Direction. Specify the circumstances when the State will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

The situations that may result in involuntary termination are described in the self-direction training guides, modules, and in trainings. The BHD has processes in place to identify mismanagement of a budget, including budget oversight and reporting by the Financial Management Service, and review of monthly budget reports by the participant's Support Broker and Case Manager.

The case manager is required to monitor the participant's budget usage on a monthly basis. The Fiscal/Employer Agent tells BHD monthly about any participant who may be over-spending their budget, if there is an advanced indication that the participant is over utilizing their budgeted amount in the electronic tracking system. The case manager also must report to the Division immediately if a participant may be over utilizing their budgeted amount outside of the agreed upon plan. A team meeting is convened by the case manager to address the over utilization and assist the participant in making changes. The Participant and case manager are notified in writing by BHD if there are serious concerns about over utilization with a warning that if utilization is not corrected in the next quarter, the BHD may pursue involuntary termination.

BHD can involuntarily terminate the use of participant direction when the following situations occur:

1) A participant or their representative is not managing the budget appropriately. BHD has processes in place to identify mismanagement of a budget, including budget oversight and reporting by the Financial Management Service, and review of monthly budget reports by the participant's Support Broker and Case Manager, as well as the BHD.

BHD works with the participant's Case Manager, Support Broker, and the Financial Management Service - Fiscal/Employer Agent to provide additional training, education and support to help the participant understand their responsibilities with managing within the budget. However, if mismanagement of the budget continues, BHD can involuntarily terminate the use of self-direction.

The Support Broker is responsible for the day to day activities in dealing with employment, managing the participant's budget, and adhering to labor laws. The Case Manager oversees, the long term of overall processes, which include developing and monitoring the plan of care. They are also required to monitor the Support Broker.

2) A participant's health and welfare needs are not adequately met. BHD has processes in place to identify when a participant's health and welfare needs are not adequately being met, including oversight by the participant's Case Manager and Support Broker, critical incident reporting, the complaint process, and oversight of self-directed services. BHD works with the participant's Case Manager and Support Broker to provide additional training, education and support to help the participant understand the need for the plan of care and for services to meet the health and welfare needs of the participant. However, if significant concerns with the participant's health and welfare continues, BHD may involuntarily terminate the participant from self-direction.

3) BHD, the Division of Healthcare Financing, and/or the Medicaid Fraud Control Unit identify situations involving the commission of fraudulent or criminal activity associated with self-direction of services. When these situations occur, BHD will work with the State Medicaid Agent, the Medicaid Fraud Control Unit and the Attorney General's office to identify the appropriate steps to take to remove the participant from participant direction of services pending the outcome of investigations.

Participants who are involuntarily terminated from self-directing are notified in writing of the involuntary termination and the reasons. The letter includes information on the right of the participant to request a Fair Hearing. When a participant is involuntarily terminated from self-direction the participant works with the case manager who follows the BHD transition process for changing services and/or service providers.

Involuntary termination of self-direction does not require that the participant change waivers, since traditional provider-based waiver services
are available on the Waiver as well as self-directed services. The transition process includes a transition team meeting to assure the team, including all providers, has current information on the changes being made to the plan of care. During the transition team meeting the case manager revises the plan of care to reflect the changes in services and service providers. The plan of care is submitted to the BHD for approval before the transitions occur. The BHD has seven calendar days to review and approve the revised plan of care.

The case manager works with the participant or their legal representative to notify the appropriate Financial Management Service provider of the termination of self-directed services and assists the participant in completing any required paperwork. BHD also has an emergency transition process in place if there are significant health and welfare concerns that may require a quicker transition out of self-directed services. This transition process requires that BHD staff are involved in the transition process so the BHD can assure the new services and service providers meet the needs of the participant and to assure the participant's health and welfare needs are met during the transition from self-direction. The case manager submits the revised plan of care to the BHD, which can approve the revised plan within one business day if an emergency situation exists.

Once a participant has been involuntarily terminated from self-direction, they cannot choose to self-direct services until their semi-annual or annual plan of care meeting, which will assure that the participant and team has an opportunity to plan the transition back to self-directed services carefully. In addition, the BHD works with the team to assure that safeguards have been put in place as necessary to assure the previous concerns or difficulties the participant had with self-directing services have been adequately addressed.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

n. Goals for Participant Direction. In the following table, provide the State's goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the State will report to CMS the number of participants who elect to direct their waiver services.

Table E-1-n

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	Number of Participants	Number of Participants
Year 1		10
Year 2		10

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	Number of participants	
Year 3		10
Year 4		10
Year 5		10

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

a. Participant - Employer Authority *Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b:*

i. Participant Employer Status. Specify the participant's employer status under the waiver. *Select one or both*:

- ☐ **Participant/Co-Employer.** The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.

  Specify the types of agencies (a.k.a., agencies with choice) that serve as co-employers of participant-selected staff:

- ☑ **Participant/Common Law Employer.** The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

ii. Participant Decision Making Authority. The participant (or the participant's representative) has decision making authority over workers who provide waiver services. *Select one or more decision making authorities that participants exercise*:

- ☑ **Recruit staff**
- ☑ **Refer staff to agency for hiring (co-employer)**
- ☑ **Select staff from worker registry**
- ☑ **Hire staff common law employer**
- ☑ **Verify staff qualifications**
- ☐ **Obtain criminal history and/or background investigation of staff**

  Specify how the costs of such investigations are compensated:

- ☑ **Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.**
- ☑ **Determine staff duties consistent with the service specifications in Appendix C-1/C-3.**
- ☑ **Determine staff wages and benefits subject to State limits**
- ☑ **Schedule staff**
- ☑ **Orient and instruct staff in duties**
- ☑ **Supervise staff**
- ☑ **Evaluate staff performance**
- ☑ **Verify time worked by staff and approve time sheets**
- ☑ **Discharge staff (common law employer)**
- ☑ **Discharge staff from providing services (co-employer)**
- ☐ **Other**

  Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (2 of 6)

b. Participant - Budget Authority *Complete when the waiver offers the budget authority opportunity as indicated in Item E-1-b:*

i. Participant Decision Making Authority. When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Select one or more*:

- [x] **Reallocate funds among services included in the budget**
- [x] **Determine the amount paid for services within the State's established limits**
- [x] **Substitute service providers**
- [x] **Schedule the provision of services**
- [x] **Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3**
- [x] **Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3**
- [x] **Identify service providers and refer for provider enrollment**
- [x] **Authorize payment for waiver goods and services**
- [x] **Review and approve provider invoices for services rendered**
- [ ] **Other**

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

b. Participant - Budget Authority

ii. Participant-Directed Budget Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

The process for determining budgets that will be self-directed and used for goods and services are determined by the participant and guardian. The self-directed service budget cannot exceed the person's assigned budget amount, which is based on assessed need. This process is explained in the self-direction materials on the Division's website. BHD assigns budget amounts for each participant on the ABI Waiver as described in Appendix C-4 of this application. The budget limit does not change if a person chooses to self-direct services. After budgeting for case management services, the participant may self-direct some or all of the budget remaining.

For budget increases, a request must be submitted and approved by the BHD Extraordinary Care Committee (ECC). An ECC database is maintained by the BHD, which summarizes the decision of all requests, including if the decision and funding is time-limited. The ECC policy, procedure and forms for requesting additional funds are available on the BHD's website for public viewing and use.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

b. Participant - Budget Authority

iii. Informing Participant of Budget Amount. Describe how the State informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

The individual budget amount is given to participants at the time funding is received for the waiver, before the plan of care is developed. Participants receive the same budget limit if they choose to self-direct services. Participants can submit requests through their case managers for an increase in the budget limit based on the plan of care development process. If the participant's team identify that the budget allotted to a participant does not meet the services and supports needed in the developed plan of care, then the participant may submit a Budget Review Questionnaire to provide more information about why his/her assigned budget and assessed need is incorrect. For significant changes in the participant's life due to a loss of a primary caregiver, health issue, or other significant event, the team may work with the case manager to request additional funding through submitting a request to the BHD Extraordinary Care Committee. The request must include specific information and evidence on the health, welfare, or service needs that cannot be met under the current budget limit, and this must be reflected in the plan of care developed by the participant's team.

The ECC may deny the request or authorize:
1) A temporary increase in the individual budget amount for up to one year, or
2) A permanent increase in the individual budget amount.

Funding requests, which are modified or denied, are eligible to request a reconsideration or a fair hearing, and the participant is notified of this right.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

b. Participant - Budget Authority

iv. Participant Exercise of Budget Flexibility. *Select one*:

- ( ) **Modifications to the participant directed budget must be preceded by a change in the service plan.**

The participant has the authority to modify the services included in the participant directed budget without prior approval.

Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

BHD reviews and approve the participant's service plan annually. During the plan year, BHD allows participants to modify services included in the participant's self-directed budget without prior BHD approval as long as the participant is not increasing the overall individual budgeted amount. The participant shall coordinate modifications to the self-directed service budget with his/her case manager, who will submit the change to the Fiscal/Employer Agent FMS. The case manager shall assure the assessed needs of the participant can continue to be met, then update the plan of care to reflect the change in services and budget. BHD will monitor the modification process to the service plan and to the budget through the representative sample file review as explained in Appendix D.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (6 of 6)

b. Participant - Budget Authority

v. Expenditure Safeguards. Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

BHD and the Vendor Fiscal/Employer Agent-Financial Management Service established safeguards for participant's budgets and to prevent the premature depletion of the budget or address potential service delivery problems that may be associated with budget over-utilization or underutilization. BHD is responsible for ensuring the implementation of safeguards developed for the participants who are self-directing. The FMS vendor chosen by BHD has a web-based system that tracks budget utilization and provides monthly reporting to participants, case managers, support brokers and BHD.

BHD and the Vendor Fiscal/Employer Agent – Financial Management Service developed business rules within their web-based system that will flag participants for possible over-utilization. For example, if the participant's claims exceed more than 20% of the expected monthly utilization, the Division and the participant's case manager will automatically be notified through an electronic message. Likewise, the rules flag participants if two consecutive pay periods bear no claims or claims total 20% under expected utilization. If premature depletion of the budget or the lack of claims are noted by the FMS' web-based system, then the BHD is automatically notified as well as the participant's case manager.

BHD staff follows up with the case manager to assure that the concern is addressed and resolved according to the BHD's monitoring processes for case managers, which includes:
• Meeting with appropriate parties involved, including the Support Broker, employee of participant who is involved in situation, and Vendor Fiscal Employer Agent Financial Management Service representative, to work through the concerns.
• Reporting issues to the BHD if significant concerns are identified that impact health and safety, indicate potentially fraudulent activity, and/or if concerns are not addressed by Vendor Fiscal Employer Agent Financial Management after the case manager has worked directly with them.

All follow up on issues reported to the BHD will be documented and reviewed quarterly for trends or to determine if:
--participant education is needed
--provider re-education is needed, or
--further actions are needed by BHD and the FMS to prevent future occurrences of the same problem.

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The State provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The State provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Individuals are notified and afforded the opportunity to request a Fair Hearing when the following occurs:
â€¢ An applicant does not meet the eligibility requirements for the waiver
â€¢ An applicant is not provided the choice of home and community-based services as an alternative to institutional care:
â€¢ A participant is denied the service(s) of their choice or the provider(s) of their choice
â€¢ A participantâ€™s services are denied, suspended, reduced or terminated

When any of these situations occur, the applicant or participant is notified in writing with specific information on how to request a Fair Hearing, in accordance with Wyoming Medicaid Rules, Chapter 4, including the time frames and procedures. The person is also informed that he/she may have an attorney, relative, friend, or other spokesperson represent them at the hearing if he/she chooses. The person has 30 days to request a fair hearing in writing to the BHD Administrator within the State Medicaid Agency. This information is also included in the Application Packet all applicants and guardians receive when applying for the ABI Waiver, and is explained by BHD staff when reviewing the application process to the applicant or guardian. If a participant is receiving waiver services, he/she is notified that services are not terminated or reduced pending the results of the Fair Hearing, unless otherwise authorized as specified in 42 CFR Â§431.230. This information is included in the letter sent to the participant or guardian. Notices of adverse actions and the opportunity to request a fair hearing are kept on file at the BHD for 6 years.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

a. Availability of Additional Dispute Resolution Process. Indicate whether the State operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

- ○ **No. This Appendix does not apply**
- ◉ **Yes. The State operates an additional dispute resolution process**

b. Description of Additional Dispute Resolution Process. Describe the additional dispute resolution process, including: (a) the State agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

In cases where a decision is made that results in adverse action against a person on the waiver, BHD offers the person an opportunity to request a reconsideration. Information on offering a fair hearing is included in the Application Packet all applicants and guardians receive when applying for the ABI Waiver, and is explained by BHD staff when reviewing the application process to the applicant or guardian. The dispute process does not prohibit a participant or guardian from requesting a hearing. After the dispute resolution process, participants will be provided another opportunity for a fair hearing in any case.

A request for reconsideration for a specific decision may be submitted to the Division Administrator if one of the following conditions is documented and supported in the request:
1) Information presented in the case was misrepresented;
2) Information was not represented to the fullest extent needed;
3) There was a misapplication of Division standards or policy in the case; or
4) The criteria for the case was misunderstood.

Providers who have a decision resulting in an adverse action are given a right to reconsideration as specified in Wyoming Medicaid Rules, Chapter 3.

If the person wants to waive the reconsideration and ask for a fair hearing, he/she may do so. In the adverse action letter, it describes the process to follow. Wyoming Medicaid Rules, Chapter 4, state that the participant has 30 days from the date of the adverse action to request a hearing if s/he disagrees with the decision by submitting a written request for an administrative hearing to the Division Administrator. The person may have an attorney, a relative, a friend, or other spokesperson, including him or herself, represented at this hearing.

The following information shall be included in the hearing request:
1) A statement of request for an administrative hearing regarding the denial;
2) The reasons why the denied request should be approved or allowed;
3) The issues to be raised at the hearing; and
4) The request must be signed; and
5) The request must be typed or legibly printed.

If a request for an administrative hearing concerning this action is submitted timely and appropriately, BHD will contract with the Office of Administrative Hearings who will notify him/her of the date, time and place of the hearing and other relevant information. Rules pertaining to administrative hearing procedures are located in Wyoming Medicaid Rules, Chapter 34, Section 15 and Chapter 1, Section 9.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

a. Operation of Grievance/Complaint System. *Select one:*

- ○ **No. This Appendix does not apply**
- ◉ **Yes. The State operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

b. Operational Responsibility. Specify the State agency that is responsible for the operation of the grievance/complaint system:

Wyoming Department of Health, Behavioral Health Division

c. Description of System. Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

ABI Waiver participants, guardians, providers, and other interested parties may file complaints with the BHD by phone, letter, email, or on the web-based complaint system available on the BHD's website. Complaints may be filed anonymously. All BHD staff are responsible a complaint received by him/her and entering the complaint in IMPROV, the BHD electronic provider management system. Complainants, who identify themselves, are sent a verification letter that the complaint has been received, next steps that will be taken, and the process of notifying them once the investigation is complete. The complaint process does not prohibit a participant or guardian from requesting a hearing.

BHD staff assesses the information in the complaint to determine if there is any suspicion of abuse, neglect, exploitation, intimidation or self-neglect, which by state law must be reported to the Protective Services unit of the Department of Family Services (DFS). In these cases, BHD completes the report the DFS and collaborates with DFS to determine the appropriate follow-up as described Section G -1 of this application. If BHD staff believes there are significant health and welfare concerns with a participant, but the complaint does not identify suspected abuse, neglect, exploitation, intimidation, or self-neglect, then the staff is required to contact their Division manager and the Provider Support manager immediately to determine appropriate follow-up actions. These are classified as Level One Complaints. The managers coordinate the follow-up on Level One complaints to assure the immediate health and welfare issues are addressed and to oversee completion of the complaint investigation.

If the BHD staff receiving the complaint does not identify significant health or welfare concerns, then they enter the complaint in IMPROV, which electronically adds the review of the complaint to the appropriate Provider Support staff's work queue for follow up. Provider Support staff review complaints entered into IMPROV within one business day to assign the priority level, the category of complaint, and to identify the appropriate investigation or follow-up actions that need to be completed. Below is more information on the priority level system in place to identify the time frame for investigating a complaint.

Level One complaints are those that indicate there are significant concerns with health, safety or rights and requires follow-up within one business day to assess and address the immediate health and safety concerns. The investigation must be completed within ten business days.

Level Two complaints are those that identify potential provider non-compliance that may be impacting the quality of services participant is receiving. The investigation must be completed within 30 days.

Level Three complaints indicate potential provider non-compliance that does not appear to be directly impacting the quality of services to the participant. Investigation must be completed within 90 days.

The final level is NAN – no action necessary. Complaint is either outside the scope of the BHD and the complainant is notified of who may have authority to investigate or the complaint does not identify any compliance issues that can be investigated.

Complaints that involve waiver policies and procedures, waiver staff, or other specific waiver issues are referred to the appropriate BHD Manager for investigation and/or follow-up. Complaints that involve provider noncompliance are referred to the appropriate BHD staff for investigation. Complaints that identify concerns with the overall service system are reviewed by the BHD's management team and, when appropriate, the DD Advisory Council to determine if changes to rules, regulations, policies or procedures need to be made.

Action steps that may be taken to investigate a complaint include:
• On-site investigation, including interviews with participant(s),staff and guardian/family members and review of provider documentation
• Requesting copies of documentation/records
• Contacting providers, staff, participants or guardians/family by telephone to gather information

BHD staff update IMPROV on the results of any complaint investigation, and notify the provider whether the complaint has been substantiated, which requires the provider to submit a corrective action plan to address the area(s) of non-compliance. The complainant is also notified of the results of the investigation following HIPAA and confidentiality laws within 7 days of the results of the investigation. If the complaint is substantiated BHD staff track the submission and approval of the quality improvement plan through IMPROV to assure the area of non-compliance is adequately addressed. The BHD's complaint process is not a prerequisite or substitution for a Fair Hearing. If complaints are received that relate to situations where a Fair Hearing can be requested, the complainant is reminded of their right to request a Fair Hearing, and the complaint process does not replace that right or delay the time lines to request a Fair Hearing. The requirements for the BHD's compliant process are found in Wyoming Medicaid Rules, Chapter 45.

Wyoming Medicaid Rules, Chapter 45 provides detailed instructions to any individual wishing to file a formal complaint against a provider. Individuals are encouraged to first address any complaints they may have regarding a particular provider with that provider; however, the BHD will accept any complaints regarding a provider. These complaints may be done by contacting a BHD employee, via e-mail, mail, or electronically through the BHD's Information for Providers System (IMPROV). The rule includes BHD's timeframes for receiving and investigating complaints. It also describes what the report will include to the provider that the complaint is against such as findings, any corrective actions, and timeframes for completion of corrective actions, and who will be notified once the investigation has been completed.

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. Critical Event or Incident Reporting and Management Process. Indicate whether the State operates Critical Event or Incident Reporting and Management Process that enables the State to collect information on sentinel events occurring in the waiver program.*Select one:*

- (●) **Yes. The State operates a Critical Event or Incident Reporting and Management Process** *(complete Items b through e)*
- ( ) **No. This Appendix does not apply** *(do not complete Items b through e)*

If the State does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the State uses to elicit information on the health and welfare of individuals served through the program.

b. State Critical Event or Incident Reporting Requirements. Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the State requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Abuse with respect to a child means inflicting or causing physical or mental injury, harm or imminent danger to the physical or mental health or welfare of a child other than by accidental means, including abandonment, excessive or unreasonable corporal punishment, malnutrition or substantial risk thereof by reason of intentional or unintentional neglect, and the commission or allowing the commission of a sexual offense against a child as defined by law (W.S. § 14-3-202.)

Per Wyoming Adult Protective Services Act (WS 35-20-103): "Any person or agency who knows or has reasonable cause to believe that a vulnerable adult is being or has been abused, sexually abused, neglected, exploited, intimidated, abandoned or is committing self-neglect, shall report the information immediately…"

Per Wyoming Medicaid Rules, Chapter 45, Waiver Provider Certification and Sanctions, Section 30, all BHD Waiver providers and provider staff are required to report incidents to the BHD, the Wyoming Department of Family Services - Protective Services Unit, Protection & Advocacy Systems Inc., the case manager, the guardian as required by law, and to law enforcement if a crime may have been committed. Reports must be filed immediately after assuring the health and safety of the participant and other individuals, and include the following categories:

- Suspected abuse, including intimidation
- Suspected Sexual abuse
- Suspected neglect
- Suspected self-neglect
- Suspected self-abuse
- Suspected abandonment
- Suspected exploitation
- Police involvement
- Injuries caused by restraints, including drugs used as restraints, physical restraints, and mechanical restraints
- Injury to the participant
* Crime committed by a participant
- Death
- Elopement

In addition to the categories above, all Waiver providers and provider staff are required to report medication errors and restraint usage to the BHD only, using the web based incident reporting system, unless the medication error or restraint is a result of suspected abuse, neglect or other reportable category listed above. In these cases the incident must also be reported to the Wyoming Department of Family Services - Protective Services Unit (DFS), Protection & Advocacy Systems Inc., the case manager, the guardian as required by law, and to law enforcement if a crime may have been committed.

Providers filing incident reports must file them through BHD's web-based system or faxed to the Division using the standardized "Notification of Incident" form. Participants, guardians, and families may contact BHD to report an incident, although they are also encouraged to report directly to the Department of Family Services Protective Services unit so DFS can gather pertinent information for their investigation. If the participant, guardian or family does not want to contact DFS, the BHD will file the report with DFS on their behalf.

c. Participant Training and Education. Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

BHD, with the help of a working group of stakeholders, developed a training video about understanding and ensuring protection from abuse, neglect, and exploitation, including how participants, families or guardians notify appropriate authorities when the participant may have experienced abuse, neglect, or exploitation.

This Abuse, Neglect, and Exploitation video is provided to participants, families, and/or guardians by BHD staff during the participant's initial acceptance of services and reviewed when BHD staff attends team meetings. Staff provides training on the content and highlights of the video answering questions the participant or family/guardian may have concerning any of these issues.

Case Managers are encouraged to review this video and information with participants on their caseload during home visits at least one time a year.

For people self-directing services, the chosen Support Broker (or case manager if there is no support broker) trains participants, their legal representatives, other members of the Circle of Support, and workers hired by participant on abuse, neglect, and exploitation. This training includes how to notify appropriate authorities when abuse, neglect, or exploitation is suspected.

During interviews with participants and guardians during the representative sample case review, BHD asks questions regarding the person's knowledge of reporting incidents of abuse, neglect, filing complaints or grievances, feeling safe, if a provider has been mean to them, and who to go to when they need help. For negative responses to questions, the BHD staff offer retraining and resources in the specific area needed.

d. Responsibility for Review of and Response to Critical Events or Incidents. Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

Per Wyoming Medicaid Rules, Chapter 45, ABI Waiver providers, provider staff, and workers employed by participants self-directing services are required to report incidents to the BHD, the Wyoming Department of Family Services - Protective Services Unit, Protection & Advocacy Systems Inc., the case manager, the guardian as required by law, and to law enforcement if a crime may have been committed. Reports must be filed immediately after assuring the health and welfare of the participant and other individuals. If a potential crime has been committed law enforcement is involved and, when appropriate, works directly with the Wyoming Department of Family Services Protective Services Unit to coordinate investigations.

If criminal charges are filed against a waiver provider or worker employed by a participant self-directing services, the BHD immediately suspends the provider pending the outcome of the criminal case. If the provider is convicted, they are immediately decertified as provider or terminated as a worker of a self-directing participant. If criminal charges are filed against provider staff, the provider is required to immediately remove the staff from providing direct care services pending the outcome of the criminal case. DFS investigates suspected abuse, sexual abuse, neglect, exploitation, self-neglect or abandonment and has an intake and referral process when incidents are reported. DFS has the statutory authority to substantiate cases, resulting in a person being listed on the Abuse Central Registry and informs the BHD when a substantiation occurs involving a Waiver provider, provider staff or worker employed by a self-directing participant. Per Chapter 45, providers appearing on the Central Registry are immediately suspended from providing services and decertified within 60 days unless they submit a new Central Registry Screening verifying they are not listed on the registry. The 60 day delay in decertification is required so the provider can appeal the DFS decision before being decertified as a provider. Protection and Advocacy, Systems Inc. (P & A) has federal authority under the Developmental Disabilities Assistance and Bill of Rights (DD) Act of 1975 and is required by the Act to pursue legal, administrative and other appropriate remedies to protect and advocate for the rights of individuals with developmental disabilities under all applicable federal and state laws. As part of this authority, P & A receives and reviews all critical incident reports involving ABI Waiver providers and participants, including participants self-directing services. P & A has a separate intake and investigation process for incidents, but does collaborate with the BHD when there are concerns with the health and welfare of participants and/or when P & A identifies potential non-compliance with rules and regulations by a Waiver provider, provider staff or worker employed by a self-directing participant.

Once a critical incident has been filed, P & A is notified by the provider immediately so that they can conduct their own investigation of the incident. P & A reviews the incident and then gives formal notice that they will be investigating the incident. This can entail interviewing the provider, provider staff involved, provider staff that were not involved but were witness to the incident, and the participant and/or guardian. Once their investigation is complete, P & A provides formal written notification to the Division, provider, and participant and/or guardian when concerns are found that impact the health and welfare of the participant. This contact entails full notification of P & A's findings to all of the above, as well as, recommendations for the state on what they feel BHD should look into and the reasons why. They also give recommendations to the participant and/or guardian on what specific rights they have when concerns have been substantiated. When P & A issues recommendations to a provider, BHD requires the provider to complete a Corrective Action Plan which identifies how they plan on addressing the issue and how they will prevent the issue from occurring in the future. The BHD investigates the incident and, when appropriate, may substantiate provider non-compliance with Medicaid rules and regulations, including concerns with participants' health and welfare. If through follow up on incident reports a provider is found to be non-compliant with rules, regulations or policies it is required to submit a corrective action plan that identifies the area of non-compliance, the action steps to be taken by the provider to address the non-compliance, the time frame for addressing each action step, and the responsible party for each action step.

Corrective action plans are due to the BHD within 15 business days if the recommendation identifies concerns with health, safety or participant rights and within 30 calendar days for all other concerns. The participant, guardian and, when appropriate the case manager are notified by letter of the non-compliance if it directly relates to the participant receiving services, adhering to HIPAA and confidentiality laws.

BHD's incident intake process is separate from the Department of Family Service's process. Incident reports are submitted by providers and other stakeholders through a web-based system. The BHD has access to the incident database via IMPROV, the BHD's web based provider management system, and are required to check for incidents throughout the day, with the requirement that they review incidents within one business day. The Provider Support Manager or designee reviews the status of reported incidents in IMPROV to assure incidents are reviewed within this timeframe. Upon receipt of an incident that identifies suspected abuse, sexual abuse, neglect, exploitation, self-neglect or abandonment, BHD staff contact the Wyoming Department of Family Services (DFS), Protective Services Unit to determine if DFS is going to open a case or if there is police involvement. If there is police involvement, or if DFS determines a reported incident is within their statutory authority to investigate, the BHD cannot complete follow-up on the specific incident until the investigations are completed. The BHD does complete immediate follow-up with the provider if there is a potential that the participant involved in the incident and/or other participants are at risk due to the provider's non-compliance with rules, regulations and policies. These are classified as Level One Incidents. The BHD notifies DFS follow-up is going to be completed and the results of the investigation are shared with DFS as appropriate. If participants continue to be at significant risk the BHD requires the provider to immediately alleviate the risks, can remove the participants if the risks are not alleviated, and can sanction the provider. The BHD uses a priority level system to identify the appropriate follow-up to be taken. Below is a summary of the levels:

Level One – Highest Consideration: Person's health or safety appears to be at immediate risk and provider compliance needs to be ensured. This requires follow-up actions by BHD within 1 business day.

Level Two – Medium Consideration: Person's health or safety is of significant concern and provider compliance needs to be ensured. This requires follow-up actions by BHD within two weeks.

Level Three – Lower Consideration: Although no substantial health and safety concerns, the incident may impact the care of the person and provider compliance needs to be ensured. This requires follow-up actions by the BHD within 2 weeks-1 month.

NAN – No Action Necessary: Adequate information and follow up have been provided. No concerns with health/safety.

BHD must review and approve the provider's corrective action plan, and monitor implementation of the plan. The type of monitoring completed on the implementation of the corrective action plan may include an on-site visit, request for documentation, follow-up interviews with participants, provider and/or provider staff, or follow-up during the next provider recertification.

All pertinent information on the review and follow-up completed on incident reports is maintained in IMPROV, including the status of corrective action plans. Information on sanctioned providers is also maintained in IMPROV. The BHD timeframes for reporting results to participants/guardians are based upon the level assigned to the incident. Level 1- 30 days, Level 2 – 60 days, and Level 3 – 90 days. Participants/guardians are notified in writing the results of the BHD's investigation into an incident.

e. Responsibility for Oversight of Critical Incidents and Events. Identify the State agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

The Department of Family Services, Protective Services unit (DFS) is responsible for overseeing and responding to critical incidents that identify suspected abuse, neglect, exploitation, self-neglect, suspected sexual abuse, intimidation or abandonment. DFS has the authority to pursue criminal charges per Wyoming State Statute 35-20-111, which states, "any person or agency who knows or has sufficient knowledge which a prudent and cautious man in similar circumstances would have to believe that a vulnerable adult is being or has been abused, sexually abused, neglected, exploited, intimidated or abandoned, or is committing self neglect, and knowingly fails to report in accordance with this act is guilty of a misdemeanor punishable by imprisonment for not more than one (1) year, a fine of not more than one thousand dollars ($1,000.00), or both." When a waiver provider, provider staff, or worker employed by a self-directing participant delays in reporting an incident, they are required to explain the reason for the delay in the incident report being filed. DFS reviews this information to determine if the provider knowingly failed to report the incident, and determines if further action is needed by DFS. Wyoming Medicaid Rules, Chapter 45 requires a provider reporting late incidents to submit a corrective action plan addressing the non-compliance. If participants continue to be at significant risk BHD requires the provider to immediately alleviate the risks, can remove participants if the risks are not alleviated, and can sanction the provider.

BHD conducts monitoring activities to assure providers are reporting incidents as required. These activities include:

Provider certification process
Providers must be recertified annually or up to three years depending on the service provided. Part of the recertification process includes assessment of providers and provider staff knowledge of reportable incidents to assure they are aware of the categories of reportable incidents and how to report. All providers are required to have an incident reporting policy that includes the requirements in the BHD's Notification of Incident process and this policy is reviewed during each provider recertification.

Incident Reporting Process
Providers are required to report critical incidents to the appropriate authorities immediately after assuring the health and welfare of the participant. BHD staff review each incident report to assure that it was reported within the required timeframe to the appropriate entities. BHD does follow-up to assure that the provider has responded appropriately to the incident and is taking appropriate action to assure the health and welfare of participants and to minimize risk. When appropriate, BHD also completes follow-up on incidents during provider recertifications as a double check to assure that the follow-up has been completed and to assess how the participant is doing.

BHD timeframes for reporting results to participants/guardians are based upon the level assigned to the incident. Level 1- 30 days, Level 2 – 60 days, and Level 3 – 90 days. Participants/guardians are notified in writing the results of the BHD's investigation into an incident. Training process for workers employed by participants self-directing services - Workers employed by participants self-directing services are required to receive training on recognizing and reporting abuse, neglect, intimidation, self-neglect, exploitation and abandonment, as well as training on the BHD's notification of incident process. This training is initially provided by the participant's Support Broker or case manager, and must be reviewed annually.

Complaint process
BHD complaint process can and has identified situations where a reportable incident occurred but was not reported as required. When this occurs, BHD requires that the provider report the incident and also requires that they submit a corrective action plan to address their failure to report incidents.

Representative Sample case review process
BHD reviews a representative sample of ABI waiver participants to assess the effectiveness of the implementation of plans of care. Included in this process is a review of incident reports and other participant specific documentation to assure incidents are reported accurately and within the timeframe required by BHD, appropriate follow-up is completed on incidents by the case manager and provider(s), and the plan of care is updated when appropriate based on the follow-up completed.

If a provider is found to be non-compliant with rules, regulations or policies it is required to submit a corrective action plan that identifies the area of non-compliance, the action steps to be taken by the provider to address the non-compliance, the time frame for addressing each action step, and the responsible party for each action step. Corrective Action plans are due to BHD within 15 business days if the recommendation
identifies concerns with health, safety or participant rights and within 30 calendar days for all other concerns. BHD must review and approve the corrective action plan, and monitor implementation of the plan. The type of monitoring completed on the implementation of the corrective action plan may include an on-site visit, request for documentation, follow-up interviews with participants, provider and/or provider staff, or follow-up during the next provider recertification.

All pertinent information on the review and follow-up completed on incident reports is maintained in IMPROV. Recommendations and corrective action plans are tracked through IMPROV as well, including verification the plan has been implemented appropriately. In addition to completing follow-up on individual incidents, BHD reviews data on incidents on a quarterly basis to identify significant trends and to determine appropriate actions to take to prevent the recurrence of incidents. Actions taken may include retraining of participants, waiver providers, and provider staff on recognizing and reporting abuse and neglect, sexual abuse, exploitation and self-neglect, distributing information to participants, guardians, and providers on causes of serious injuries that can be avoided, such as assuring participants have proper footwear in the winter to avoid falls, working with a specific provider who has an increase in incidents identifying specific concerns with

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

a. Use of Restraints. *(Select one): (For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)*

○ **The State does not permit or prohibits the use of restraints**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:

◉ **The use of restraints is permitted during the course of the delivery of waiver services**. Complete Items G-2-a-i and G-2-a-ii.

i. Safeguards Concerning the Use of Restraints. Specify the safeguards that the State has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Although the state is exploring ways of reducing or even eliminating all restraints in the future, restraints are allowed in some instances and safeguards are in place and must be practiced by providers.

Safeguards for restraint usage are written into Wyoming State Statute 35-1-625 and 626, which mandate participants must be free from physical restraints and isolation except for emergency situations or when isolation or restraint is a part of a treatment program; and isolation or restraint of a participant may be used only when less restrictive measures are ineffective or not feasible for the welfare of the participant and shall be used for the shortest time possible.

BHD has specific safeguards in place concerning use of restraints in Wyoming Medicaid Rules, Chapter 45, which prohibits the use of seclusion in home and community based waiver services. In Chapter 45, Section 27, restraints are defined as:
• Drugs used as a restraint: Any drug that is administered to manage a participant's behavior in a way that reduces the safety risk to the participant or others, and has the temporary effect of restricting the participant's freedom of movement, and is not a standard treatment for the participant's medical or psychiatric condition.
• Mechanical restraints: Any device attached or adjacent to a participant's body that he or she cannot easily move or remove that restricts freedom of movement or normal access to the body.
• Personal restraints: The application of physical force or physical presence without the use of any device, for the purposes of restraining the free movement of the body of the participant. The term personal restraint does not include briefly holding, without undue force, a participant in order to calm or comfort him or her, or holding a participant's hand to safely escort him or her from one area to another.
• Emergency restraints: A restraint used in an emergency due to significant concerns with the health and welfare of the participant or others, which is not authorized in the participant's plan of care.

Any restraint usage, must be ordered by a physician or qualified behavioral health practitioner, written in the participant's plan of care, and reviewed and approved by the participant, guardian, and the Division. The plan of care indicates that the person-centered plan identifies the specific and individualized need related to the use of a restraint; and the provider must document which positive interventions and support will be used prior to the use of more restrictive methods; and must require that less intrusive methods that have been tried and documented if they did not work prior to use of a restraint. The consent is written by signing the plan and consent can be withdrawn when desired. The written documentation of consent on the plan is kept according to the Division's maintenance of recordsLeast restrictive measures must be attempted first, and when restraint usage is identified in the plan of care, a crisis intervention plan and a positive behavior support plan must be developed that focuses on positive interventions.

Providers are required to document that the participant has been consulted regarding alternatives he or she prefers prior to the development of the positive behavior support plan that includes the use of restraint, when possible. All providers are required to have policies on restraint usage, including a policy on whether they will use emergency restraints, such as a personal restraint, as a time-limited emergency measure until the appropriate law enforcement, safety or other emergency service providers arrive on site. When an emergency restraint occurs, providers are required to notify the guardian and case manager so the case manager can convene a team meeting to assess the use of the emergency restraint and to work with the participant and team on identifying appropriate changes to the plan of care. These changes may include authorization of restraint usage, but the team is encouraged to consider less intrusive methods if appropriate.

Providers are required to report the restraint to the Division using the BHD notification of incident process. They also must document the use of restraints as an incident following the provider's internal incident reporting policy. Restraint usage must be reported to the BHD completes follow-up monitoring to assure the team meets and the plan of care is revised appropriately.

All rights restrictions in the plan of care, including restraint usage, have to identify the following:
1) Why the restriction is imposed
2) How it is imposed
3) A plan to restore rights
4) A date to review restrictions

Providers using restraints must assure less restrictive intervention techniques are used prior to the use of restraint, assure the individualized plan of care includes limitations or specific descriptions of the proper restraint to use or not use on the participant, and identify the designated provider staff to provide face-to-face evaluation of the participant within one hour of the use of restraint to assure there are no injuries or other concerns and to assure the provider staff are following the participant's plan of care and restraint standards, including using the least restrictive approach first.

Providers are required to obtain and maintain restraint training from entities that are certified to conduct such training before agreeing to provider services for any participant who has restraint use in the plan of care. Staff involved in the direct administration of restraints must also receive initial and annual competency-based training in the following:
1) The contributing factors or causes of threatening behavior.
2) The use of alternative interventions, such as mediation, de-escalation, self-protection, and time out, which still permits the participant the freedom to leave the time-out area
3) Recognizing signs of physical distress in the person who is being restrained.
4) The re-establishment of communication after a person has been restrained.
5) The prevention of threatening behaviors
6) When and how to restrain safely

Removal from restraint must occur as soon as the threat of harm has been safety minimized. Restraint cannot be used as coercion, discipline, convenience, or retaliation by staff. Analysis of restraint usage occurs on the participant level, provider level and at the state level as described below:
1. Providers are required to review and discuss each use of restraint. The participant, the guardian and staff are included in the discussion, which should address:
• The incident.
• Its antecedents.
• The reasons for the use of restraint.
• The person's reaction to the intervention.
• Actions that could make future use of restraint unnecessary.

When applicable, modifications should be made to plan of care to address issues or behaviors that impact the need to use restraint.

2. The restraint must be reported to BHD.

3. The chief executive or designated management staff member is required to review and sign off on all uses of restraint after every occurrence. The review must include:
• Verification that the provider's policies and procedures regarding restraints were followed
• Verification that the behavior support plan for the participant was followed
• Determination if modifications to the treatment plan are needed
• Determination if staff involved in the restraint had received appropriate training and utilized this training appropriately when using a restraint
• Verification that recommendations identified during the review of the restraint usage are appropriate and are being implemented

4. Case managers are required to complete an analysis of restraint usage monthly for each participant to identify trends and to work with the team to make appropriate changes to the plan of care as needed. Data on restraint usage is submitted to BHD quarterly. The state requires in rule that providers who use restraints have internal systems in place to follow up on restraint and restriction usage and remediate their processes as necessary. If a restraint results in a

critical incident, providers have to report it to BHD as a critical incident and will warrant involvement from the BHD according to the state's criteria specified in Appendix G-1.

Waiver certified case managers are responsible for ensuring a participant's safeguards by keeping accurate up-to-date records regarding a participant's restraint usage and restrictive interventions identified in their crisis intervention plans. Case managers are given this information through an internal incident report provided by the direct care staff or their supervisor after a restraint has occurred and when a restrictive intervention has taken place. Case managers review this information on a regular basis to analyze any trends and report this information to the Division on a quarterly basis.

5. The use of restraint must be recorded in the provider's information system and reviewed for:
- Analysis of patterns of use
- History of use by personnel
- Environmental contributing factors
- Assessment of program design contributing factors

If the frequency of use of restraint, including physical restraint, mechanical restraint, and chemical restraint changes, the chief executive or a designee must investigate the pattern of use and take action to continuously reduce or eliminate the use of restraint.

6. BHD oversees the use of restraints or seclusion and ensures that State safeguards concerning their use are followed as described in G-2-a-ii.

ii. State Oversight Responsibility. Specify the State agency (or agencies) responsible for overseeing the use of restraints and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

BHD monitors compliance with restraint rules through the plan of care approval process, provider recertification process, representative sample process, incident-reporting process, complaint process and Extraordinary Care Committee review process. The focus of this monitoring is to assure restraint usage is only occurring when necessary as a last resort, is authorized as required in state rules, is approved in the plan of care, and to assure staff have appropriate training in both restraint usage and in de-escalation techniques and other non-evasive approaches to working with participants.

Plan of Care Approval Process
BHD staff review and approve each plan annually. This review includes a review of authorized restraints written in the plan of care to assure the restraint is ordered by a physician or qualified behavioral health practitioner, has been approved by the guardian and participant, that least restrictive measures were attempted first, and a crisis intervention plan and a positive behavior support plan is included in the plan of care that focuses on positive interventions. The review also includes assuring seclusion is not listed in the plan as a restriction.

Provider Recertification Process
Providers are initially certified for one year and are required to complete a recertification at the end of the first year. After the initial year certification, BHD may certify an agency for up to three years depending on the service they are providing. Agencies who receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights, habilitation, or have few recommendations in other areas reviewed receive up to a one year recertification, and agencies (that don't provide residential support services or Community Integration Habilitation) who do not receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights, habilitation, or have multiple recommendations in other areas reviewed may receive up to a three year recertification, if applicable to the service being provided (as specified in Appendix C - provider qualifications). The recertification process includes monitoring the use of restraints to ensure that state requirements are being followed and to detect unauthorized, inappropriate or ineffective use of restraints and use of seclusion. This monitoring includes:
• A review of provider/provider staff files to verify the provider has current training from an entity certified to conduct the training, such as MANDT or CPI.
• Interviews with providers and provider staff about restraint usage to assure restraints are only used when absolutely necessary and it is written into the participant's plan of care, and to verify seclusion is not being used.
• A review of the provider's information system and results of the analysis of restraint use to assure trends are being identified and areas of concern are addressed at the provider level.
• Workers of participants self-directing services will be required to meet the same standards as all providers and provider staff.
• A review of each provider's policies and procedures on restraint usage and on emergency restraints, including verification the policy states seclusion will not be used.

Representative Sample Review
• BHD completes a review of the implementation of plans of care, including a review of restraint and restrictive intervention usage and tracking, for a representative sample of Waiver participants, including participants self-directing services. The representative sample has a 95% confidence level and a margin of error of 5%. The sample is completed throughout two years and is combined with the sample of other BHD waivers.

Included in this review:
• A review of case management documentation of Waiver participants, including participants self-directing services, for a six month period to verify the case manager is consistently monitoring use of restraints and restrictive interventions, including completing follow-up when concerns are found and updating the plan as needed.
• A review of a representative sample of participant files to assess the documentation of restraint usage, including the documentation of the review and discussion required after each use of restraints. This includes a review of case management documentation for the random sample of participants to verify the case manager has completed the monthly evaluation and trend analysis of restraint usage and has completed appropriate follow-up on concerns.

Incident and Complaint Processes
Restraint usage is reported through the BHD incident reporting system. They also may be submitted as a complaint. When reported, BHD reviews the participant's plan of care to assure that restraint usage is authorized and that a positive behavior support plan and crisis intervention plan is in place and was followed. Incidents and complaints are reviewed to verify seclusion is not being used.

Extraordinary Care Committee Review Process:
When BHD's Extraordinary Care Committee approves an increase in a participant's budget, BHD staff complete follow-up as appropriate to verify the funding is being utilized appropriately and the need for the additional funding still exists. This review may include a review of participant specific documentation, including documentation of restraints and restrictive interventions used, to assure rules and standards are being followed.

The unauthorized or inappropriate use of restraints and the use of seclusion can be uncovered through any of the processes listed above. If the unauthorized use of restraints is found, the provider is required to immediately put safeguards in place to assure there are no more restraints used until the team is able to evaluate the reason for the unauthorized restraint and to identify appropriate follow up actions. If the use of seclusion is found, the provider is notified to immediately stop the practice and BHD completes an on-site investigation to assure seclusion is not being used. Per Wyoming Medicaid rules, Chapter 45, the Division of Healthcare Financing - State Medicaid Agency completes a recovery of funds for the services provided at the time seclusion was used.

If a provider is found to be non-compliant with rules, regulations or policies, including the unauthorized use of restraints, it is required to submit a corrective action plan that identifies the area of noncompliance, the action steps to be taken by the provider to address the non-compliance, the time frame for addressing each action step, and the responsible party for each action step. Corrective action plans are due to BHD within 15 business days if the recommendation identifies concerns with health, safety or participant rights and within 30 calendar days for all other concerns. BHD must review and approve the corrective action plan, and monitor implementation of the plan. The type of monitoring completed on the implementation of the corrective action plan may include an onsite visit, request for documentation, follow-up interviews with participants, provider and/or provider staff, or follow-up during the next provider recertification.

The EMWS allows case managers to report information on restraint and restrictive intervention usage by participant on quarterly basis.
In addition to monitoring restraint and restrictive intervention data on the participant and provider level, BHD reviews aggregate data quarterly to identify systemic trends in this area that may need addressing before the annual review of data and information as outlined in the Quality Improvement Strategy section of this application (Section H.) Examples of how trends may be addressed by BHD include, enhancing training in this area, releasing a bulletin clarifying a standard or rule, and/or revising the plan of care approval process to assure restraint or restrictive interventions are appropriately approved during the plan review. The goal is to assure restraint and restrictive interventions are only used when necessary and per rules and standards.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

b. Use of Restrictive Interventions. *(Select one)*:

- ○ **The State does not permit or prohibits the use of restrictive interventions**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

The use of restrictive interventions is permitted during the course of the delivery of waiver services Complete Items G-2-b-i and G-2-b-ii.

i. Safeguards Concerning the Use of Restrictive Interventions. Specify the safeguards that the State has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

BHD has specific safeguards in place concerning use of restrictive measures in Wyoming Medicaid Rules, Chapter 45. Restrictive interventions are defined as any temporary restriction imposed by a provider towards a participant due to a participant's health or behavioral crisis. Restrictions to community outings, communication, privacy, and possessions are the specific restrictions which providers may impose due to the immediate health or safety of a participant, their peers or community members. Restrictive interventions include:
• limits on a participant's movement
• limits on a participant's access to other individuals, locations or activities
• the use of other aversive techniques (not including restraint or seclusion) that are designed to modify the participant's behavior. Aversive techniques may include restrictions on a person's possessions, property, communication, privacy, or interactions with other individuals. These must be written into the plan of care with all of the criteria above being met.

Restrictive interventions must be included in the plan of care and reviewed and approved by the participant, guardian and the BHD. The plan of care must also include a plan to restore rights and periodic reviews of the restrictions. The BHD has specific safeguards in place concerning use of restrictive interventions, which include least restrictive measures must be attempted first; and, when restrictive interventions are identified in the plan of care, a positive behavior support plan must be developed that focuses on positive interventions. Providers are required to document that the participant has been consulted regarding alternatives he or she prefers prior to the development of the behavior support plan that includes the use of restrictive interventions, when the participant can express preferences.

All rights restrictions in the plan of care, including restrictive interventions, have to identify the following:
1) Why the restriction is imposed
2) How it is imposed
3) A plan to restore rights
4) A date to review restrictions

Providers and provider staff are required to receive participant specific training, including training on rights restrictions and restrictive interventions. Providers are required to document the use of restrictive interventions as an incident following the provider's internal incident reporting policy. Analysis of use of restrictive interventions occurs on the participant level, provider level and at the state level as described below:
1) Providers are required to document each use of restrictive interventions and to review the use of the restrictive intervention to assure it was authorized in the participant's plan of care and implemented appropriately
2) Case managers are required to complete an analysis of restrictive interventions monthly for each participant to identify trends and to work with the team to make appropriate changes to the plan of care as needed.
3) BHD oversees the use of restrictive interventions and ensures that State safeguards concerning their use are followed as described in G-2-b-ii.

ii. State Oversight Responsibility. Specify the State agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

BHD monitors compliance with restrictive interventions through the plan of care approval process, provider recertification process, incident-reporting process, and complaint process. The focus of this monitoring is to assure restrictive interventions occur only when necessary as a last resort, are authorized as required in state rules, are approved in the plans of care, and to assure staff have appropriate training in approved restrictive interventions for each participant.

Plan of Care Approval Process:
BHD staff review and approve each plan annually. This review includes a review of restrictive interventions written in the plan of care to assure the restrictive intervention has been approved by the guardian and participant, least restrictive measures were attempted first, and a positive behavior support plan is included in the plan of care that focuses on positive interventions.

Provider Recertification Process:
Providers are initially certified for one year and are required to complete a recertification at the end of the first year. After the initial year certification, BHD may certify an agency for up to three years depending on the service they are providing. Agencies who receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights, habilitation, or have few recommendations in other areas reviewed receive up to a one year recertification, and agencies (that don't provide residential support services or Community Integration Habilitation) who do not receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights, habilitation, or have multiple recommendations in other areas reviewed may receive up to a three year recertification, if applicable to the service being provided (as specified in Appendix C - provider qualifications). The provider recertification process includes monitoring the use of restrictive interventions to ensure that state requirements are being followed and to detect unauthorized, inappropriate or ineffective use of restrictive interventions. This monitoring includes:
• Review of provider/provider staff files to verify the provider has current training on restrictive interventions written into each participant's plan of care Interviews with providers and provider staff about use of restrictive interventions to assure they are only used when necessary and are written into the participant's plan of care.
• Review of the provider's information system and results of the analysis of restrictive intervention use to assure trends are being identified and areas of concern are addressed at the provider level
• Review of a representative sample of Waiver participant files to assess the documentation of use of restrictive interventions. The biennial representative sample size has a 95% confidence level and a margin of error of 5%. This includes a review of case management documentation for the random sample of Waiver participants to verify the case manager has completed the monthly evaluation and trend analysis of use of restrictive interventions and has completed appropriate follow-up on concerns.

Incident and Complaint Processes:
When use of restrictive interventions is reported through incidents or complaints, BHD reviews the participant's plan of care to assure that the use of restrictive interventions authorized and that a positive behavior support plan and crisis intervention plan is in place and was followed. The unauthorized or inappropriate use of restrictive interventions can be uncovered through any of the processes listed above. When this occurs the provider is required to immediately put safeguards in place to assure there are no more restrictive interventions used until the team is able to evaluate the reason for the unauthorized restrictive intervention and to identify appropriate follow up actions.

If a provider is non-compliant with rules, regulations or policies, including the unauthorized use of restrictive interventions, it is required to submit a corrective action plan that identifies the area of non-compliance, the action steps to be taken by the provider to address the non-compliance, the time frame for addressing each action step, and the responsible party for each action step. Corrective Action plans are due to the BHD within 15 business days if the recommendation identifies concerns with health, safety or participant rights and within 30 calendar days for all other concerns. The BHD must review and approve the corrective action plan, and monitor implementation of the plan. The type of monitoring completed on the implementation of the corrective action plan may include an on-site visit, request for documentation, follow-up interviews with participants, provider and/or provider staff, or follow-up during the next provider recertification. The BHD collects data on restraints and restrictive interventions quarterly.

Restraint and restrictive intervention data:
Each quarter, case managers are required to submit via EMWS any restraints and restrictive interventions used on each participant on his/her caseload, including the type of restraint and/or restrictive intervention. The Participant Support Manager reviews with other BHD staff to monitor the data for trends and concerns in order to conduct necessary follow up.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

c. Use of Seclusion. *(Select one): (This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

◉ **The State does not permit or prohibits the use of seclusion**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:

BHD specifies the prohibition of the use of seclusion in home and community based waiver services in Wyoming Medicaid Rules, Chapter 45, Section 17:

(i) Providers may not involuntarily confine a participant alone in a room, in an area from which the participant is physically prevented from leaving, or physically restraint a person back to a room once he or she leaves during the provision of the waiver services. The use of any type of seclusion in this manner is not allowable under Medicaid funded services and will require a referral to Medicaid for a full recovery of funds.

BHD monitors compliance with state standards for restraints, restrictive interventions and possible use of seclusion through the plan of care approval process, provider recertification process, incident-reporting process, and complaint process. The focus of this monitoring is to assure seclusion is not occurring and that restraints and restrictive interventions occur only when necessary as a last resort, are authorized as required in state rules, are approved in the plans of care, and to assure staff have appropriate training per state rules.

Plan of Care Approval Process:
BHD staff review and approve each plan annually. This review includes a review of restraints and restrictive interventions written in the plan of care to assure seclusion is not present.

Provider Recertification Process:
Providers are initially certified for one year and are required to complete a recertification at the end of the first year. After the initial year certification, BHD may certify an agency for up to three years depending on the service they are providing. Agencies who receive a recommendation that identifies non-compliance with rules BHD specifies the prohibition of the use of seclusion in home and community based waiver services in Wyoming Medicaid Rules, Chapter 45, Section 17:

○ **The use of seclusion is permitted during the course of the delivery of waiver services**. Complete Items G-2-c-i and G-2-c-ii.

i. Safeguards Concerning the Use of Seclusion. Specify the safeguards that the State has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

ii. State Oversight Responsibility. Specify the State agency (or agencies) responsible for overseeing the use of seclusion and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. Applicability. Select one:

- **No. This Appendix is not applicable** *(do not complete the remaining items)*
- **Yes. This Appendix applies** *(complete the remaining items)*

b. Medication Management and Follow-Up

i. Responsibility. Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

First line monitoring:
The participant's physician, psychiatrist, or other licensed medical professional who prescribes medications to the participant shall be the first line monitor of the participant's medication regimen. The first line monitor shall be accessed by the participant, guardian, case manager and designated team member(s) to conduct regular assessments of medication regimens, side effects, or when concerns arise regarding a participant's treatment plan, health condition or potentially harmful contraindicated medications are used.

Second line monitoring: Medication regimens shall have a second line of monitoring conducted by the participant's case manager, in conjunction with designated members of the participant's team. Case Managers shall monitor medication regimens by:
1) Ensuring all medications, medical treatments, and medication assistance are described accurately and fully in the plan of care and updated as needed.
2) Ensuring providers receive training on the participant's plan of care.
3) Conducting reviews of events as defined in the state's medication assistance policy.
4) Ensuring professional medical assessments are performed at least annually, or as needed by responsible parties, to include:
a) Medication reviews to prevent the concurrent use of contraindicated medications
b) Blood tests and liver function tests to monitor the effects of psychotropic or seizure medications on one's body
c) Any follow up medical visits needed to monitor the participant's health post-injury, post-surgery, or after any significant change in treatment plan
5) Documenting review of the participant's health, medical condition, medication regimen, incident reports, PRN usage, and pertinent health risks at least quarterly on the case management quarterly form, or as deemed appropriate for the participant by the participant's medical professional. At least quarterly, or as health or safety risks arise, the case manager must monitor the participant for significant health changes, including:
a) Significant changes in weight (either weight gain or loss)
b) Increase in seizure activity or changes in type or duration of seizures
c) Unplanned changes in diet and/or food intake
d) Changes in adaptive equipment needs or in condition of equipment
e) Significant changes in type or frequency of behaviors
f) Changes in medication
g) Use of PRN medications
h) Any other significant health changes
i) Follow up actions taken on Incident Reports, PRN usage, or other identified health risks or concerns

Monitoring of PRN usage:
A qualified person, in accordance with state standards, who a provider deems responsible for analyzing the patterns of PRN usage, will work in conjunction with the participant's case manager to assure an appropriately trained medical professional continually assesses, monitors, and re-evaluates the participant to determine if the PRN medication is still needed or is still appropriate for the participant's medical condition.

The frequency of the monitoring, which shall be done at least quarterly by the case manager but may be needed more frequently for some participants or types of medication.

Monitoring Behavioral Modifying Medication:
First line monitoring of behavioral modifying medication shall be the responsibility of the participant's physician, psychiatrist, or other licensed medical professional who prescribes medications to the participant. The first line monitor shall be accessed by the participant, guardian, case manager and designated team member(s) to conduct regular assessments of medication regimens, side effects, or when concerns arise regarding a participant's treatment plan, health condition or potentially harmful contraindicated medications are used.

Second line monitoring of behavioral modifying medication shall be conducted by the participant's case manager, in conjunction with designated members of the participant's team.

When a medication is given for the purposes of modifying a behavior, the provider shall have policy and procedures for assisting and monitoring medication in compliance with the state's standards. The policy and procedures shall include:
1) The qualified person(s) responsible for assisting the participant with medications. A physician or psychiatrist continually assesses, monitors, and re-evaluates the participant to determine if the behavioral modification medication is still needed, is having adverse effects on the participant, or is still appropriate for the participant's medical condition.
2) How the medication will only be used in accordance with the type, frequency, duration, route, and specific instructions as prescribed by the participant's physician or psychiatrist involved in his/her treatment plan.
3) The need for specific instructions for behavioral modifying PRN medications to be detailed in the participant's Positive Behavior Support Plan, to include:
a) The interventions and supports that should be tried by the provider before the administration of a psychoactive PRN medications.
b) The specific symptoms for which the psychoactive PRN medication has been prescribed.
4) Documentation of the use of psychoactive medications through the generation of an internal incident report, to include:
a) The behavior displayed by the participant.
b) The non-pharmacological de-escalation interventions attempted by the staff.
c) The psychoactive PRN medication administered, including amount and route.
d) The effects of the psychoactive PRN medication on the participant.
5) Identifying the person responsible for conducting a review of the incident requiring use of the PRN psychoactive medication.
6) The requirements of the incident review, to include:
a) Verification that the provider's policies and procedures regarding medication assistance and the participant's PRN protocols in the plan of care were followed.
b) Verification that the positive behavior support plan for the participant was followed, including less restrictive techniques.
c) Determination if staff involved in the use and administration of the PRN had received appropriate training in accordance with the Division standards and utilized this training appropriately when assisting with the PRN psychoactive medication.
d) If PRN psychoactive medications are given frequently, then the provider shall notify the prescribing medical professional(s) and report all psychoactive medication usage by a participant, including any instances of PRN administration and chemical restraints. A change to the treatment plan, positive behavior support plan, and/or the plan of care or a change in standing medication orders may be needed.
7) Recording the review of each PRN used in the provider's information system and reviewed for:
a) Analysis of patterns of use.
b) History of use by personnel.
c) Environmental contributing factors.
d) Assessment of program design contributing factors.
8) If PRN psychoactive medication usage is suspicious or raises concerns regarding the participant's health and safety, then the provider shall investigate the pattern of use and take action to continuously reduce or eliminate the PRN usage, or otherwise address the medication regimen with the participant's physician or psychiatrist.
9) Any concerns or incidents that qualify as a critical incident according to the Division's state requirements shall be filed with the BHD as described in Appendix G-1-d.

ii. Methods of State Oversight and Follow-Up. Describe: (a) the method(s) that the State uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the State agency (or agencies) that is responsible for follow-up and oversight.

To ensure appropriate medication management by providers, all providers assisting participants with medication regimens must comply with the state requirements for medication assistance, including:

1) The development and implementation of internal medication assistance policies and procedures that meet the Division's standards.
a) Through implementation of the provider's policies and procedures, the provider ensures:
i) Only prescribed medication, or medications specified through consent of the participant or guardian and deemed appropriate by the participant's medical professional, shall be included in the participant's medication regimen.
ii) Only qualified persons, as dictated by Division's standards, assist a participant with medications.
iii) The participant receives consistent and appropriate assistance with the medication as described by the prescription and instructions from the participant's medical professional.
2) The participant, or guardian if applicable, gives consent to allow a provider to assist with the participant's medication.
3) Only qualified persons, which is a licensed medical professional or a state Approved Medication Assistant, assist a participant with medication. To become an Approved Medication Assistant, the provider or provider staff must complete the required training.
4) The participant's case manager, in conjunction with designated member(s) of the participant's team, oversees the ongoing monitoring of the participant's medication regimen as described in the plan of care.
5) The assistance needed by the participant is accurately reflected in the plan of care, including any other special instructions or participant education needed for assisting with the medication, and providers must be trained on the participant's plan of care.

The BHD is responsible for overseeing and monitoring provider compliance with the Division's medication assistance policy and standards, potentially harmful practices and the provider's own policies and procedures.

The BHD oversees provider compliance with state standards and requirements through the Participant Support Specialists attending team meetings, the Provider Support unit completing recertifications, participant support specialists approving each plan of care, and as needed through follow up to critical incidents reported. Through these regular channels of communication and monitoring, the State ensures that participant medications are managed appropriately and monitors for potentially harmful practices.

The case manager and all providers are responsible for reporting unsafe practices to the BHD through the critical incident reporting process, complaint process and reporting critical medication errors to the BHD. Through critical incident reports, complaints, provider certification or recertification processes, the Division completes follow up on any identified health or safety concerns regarding medication assistance. During follow up of a medication assistance concern the Division may review the provider's:
1) Medication assistance policies and procedures
2) Medication error policies and procedures
3) Medication-related forms, including
a) Incident Reports
b) Medication Assistance Records (MARs)
c) Medication Error forms
d) Medication and/or PRN reviews
e) Case management documentation of follow up

If the Division identifies health or safety concerns regarding medication assistance, such as unsafe practices or non-compliance with the Division's standards and requirements, then the provider must:
1) Rectify the situation as quickly as possible, subject to approval by the Division
2) Receive re-education on the Division's standards, policy and procedures on Medication Assistance,
3) Train or retrain personnel as needed to safely assist participant's with medication, and
4) Address the areas of non-compliance before the next recertification is completed.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. Medication Administration by Waiver Providers

i. Provider Administration of Medications. *Select one:*

- ○ **Not applicable.** *(do not complete the remaining items)*
- ◉ **Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.** *(complete the remaining items)*

ii. State Policy. Summarize the State policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

State Policy: BHD shall ensure participant medications are managed and monitored in accordance with the State's standards by requiring all home and community-based waiver providers, who assist participants with medications, to develop and implement policies and procedures in accordance to the standards listed herein.

STANDARDS
Providers assisting participants with medication regimens must comply with the state requirements for medication assistance as listed in this policy.
1) The participant or guardian must give consent to allow a specific provider or providers to be recognized as "friends" in accordance with the Wyoming Nursing Practice Act, Title 22, Chapter 21, 33-21-154, (iii) which allows for "the incidental health care by members of the family and friends." This allows the Division to get medical consent from participants and families to permit providers to assist with medications.
2) During waiver services, only qualified persons can assist a participant with medication. Qualified persons include licensed medical professionals who can administer medications within the scope of the medical licensure, or Medication Assistants who completed and passed the state approved curriculum and competency based test. Retraining is required at least every two (2) years.
3) If an Medication Assistant has a medication error, BHD reviews the error to possibly require retraining contingent upon the findings of the investigation.
i) Retraining includes an overview of the original curriculum, observation of medication assistance tasks by an approved medication assistant trainer or licensed medical professional and satisfactory completion of a competency-based test approved by the Division.
4) The participant's case manager, in conjunction with designated member(s) of the participant's team, oversees the ongoing monitoring of the participant's medication regimen as described in the plan of care.
5) The assistance needed by the participant must be accurately reflected in the plan of care, including any other special instructions or participant education needed for assisting with the medication.
6) The provider must comply with the Division's standards for medication assistance and the provider's own internal medication assistance policies and procedures, which cover:
i) Medication Consent
ii) Qualified Persons to assist with medications
iii) PRN protocol
iv) Behavioral Modifying Medications
v) Medication Storage and Labeling
vi) Medication Records
vii) Medication Assistance Records
viii) Medications Off-site
ix) Medication Error Reporting

7) The policies and procedures must also include verification that:
i) Only prescribed medication, or medications specified through consent of the participant or guardian and deemed appropriate by the participant's medical professional, are included in the participant's medication regimen.
ii) Only qualified persons assist a participant with medications.
iii) The participant receives consistent and appropriate assistance with the medication as prescribed by the participant's medical professional.

8) The Division oversees provider medication management and assistance and potentially harmful practices by monitoring providers' compliance with these standards through critical incident reports, complaint followup, certification and recertifications, or as the need of a participant arises. Requirements of State monitoring is detailed in Appendix G-3-c-iv of this application.

iii. Medication Error Reporting. *Select one of the following:*

Providers that are responsible for medication administration are required to both record and report medication errors to a State agency (or agencies).
Complete the following three items:

(a) Specify State agency (or agencies) to which errors are reported:

Wyoming Department of Health, Behavioral Health Division

BHD will involve the Department of Family Services, Protective Services Unit, Protection & Advocacy, and law enforcement if an error is reported that falls into one of the other reportable incident categories, which requires notification to the other parties included in the BHD Notification of Incident process.

(b) Specify the types of medication errors that providers are required to *record:*

All providers are required to develop policies and procedures to comply with the following BHD standards for recording, reporting and tracking medication errors. Medication errors that providers are required to record include:
i) Wrong medication
ii) Wrong dosage
iii) Missed medications
iv) Wrong participant
v) Wrong route
vi) Wrong time – Deviation from accepted standard time frame for the medication assistance
(1) Standard Medication Assistance Time frame is one hour before or after the scheduled time of medication assistance or as prescribed due to special circumstances, i.e. mealtimes.

Also, providers have additional medication errors or incidents that are reportable within their organization, but not reportable to the BHD. These categories include:
i) Refusals,
ii) Dropped medication,
iii) Expired or damaged medication,
iv) Other medication events determined to need action

(c) Specify the types of medication errors that providers must *report* to the State:

Medication errors reportable by the provider within one business day to BHD include any occurrence of the following:
* Wrong medication
* Wrong dosage
* Missed medication
* Wrong participant
* Wrong route
* Wrong Time – Deviation from accepted standard time frame for the medication assistance

Medication Assistance Time frame is one hour before or after the scheduled time of medication assistance or as prescribed due to special circumstances, i.e. mealtimes).

Medication Errors reported to BHD do not have to be reported to Protection & Advocacy Systems, Inc., Department of Family Services, or police unless a crime has been committed, such as medication diversion or other misuse of medication. BHD reviews the medication error and determine if the incident must be reviewed by other investigative parties for further follow up.

Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the State.

Specify the types of medication errors that providers are required to record:

iv. State Oversight Responsibility. Specify the State agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

BHD is responsible for monitoring the performance of Comprehensive Waiver providers who assist participants with medications. Monitoring occurs through regular contact with providers. BHD staff attending team meetings monitor the medication regimen being written in the plan and follow up that is discussed with team members. BHD staff review and approve each plan of care to assure the participant's assessed needs and medical information align with the medication and medical treatment outlined in the plan. BHD completes participant file reviews and various participant and staff interviews during certification and recertification processes, and conducts investigations and follow up for critical incidents or complaints reported to the Division's critical incident reporting system, managed in IMPROV. Through these regular channels of communication and monitoring, the State ensures that participant medications are managed appropriately and monitored for potentially harmful practices.

How monitoring is performed:
Monitoring compliance with the state standards occurs during regular contact with providers, such as team meetings, site surveys during recertifications, plan of care review, and incident report or complaint follow up.

Medication errors reported through the BHD's critical incident reporting system are tracked through the IMPROV database and reviewed within one business day by BHD staff. If a medication error is reported through a critical incident report, the BHD will investigate the incident to ensure the necessary follow up is conducted to rectify the situation and prevent further occurrences. Follow up may include requiring re-training for the provider or provider employee associated with the medication error. In these cases, the provider will have to pass the competency based test for medication assistance with 100% accuracy before continuing to assist with medications.

When any member of the BHD notices a problem with a provider's medication assistance practices, an internal referral is made through the Division's provider management system, IMPROV. BHD staff within the Division are responsible for completing follow up as needed on the referral. Examples of problematic medication assistance are any medication error, misuse of a participant's medication, or unsafe practices that are not in compliance with the state standards. IMPROV tracks the details of the referral and the follow up actions taken by BHD staff to remediate the problem with the provider. If changes are made to medications or treatment plans as a result of the meeting or follow up medical appointments, then changes to the plan of care are made by the case manager and distributed to team members.

Follow up requirements vary depending upon the concern identified, but the monitoring may include a review of the provider's:
1) Medication assistance policies and procedures
2) Medication error policies and procedures
3) Medication-related forms, including
   a) Incident Reports
   b) Medication Assistance Records (MARs)
   c) Medication Error forms
   d) Medication and/or PRN reviews
4) Case management documentation of follow up

If the Division identifies health or safety concerns regarding medication assistance, such as unsafe practices or non-compliance with the Division's standards and requirements, then the provider must:
1) Rectify the situation as quickly as possible, subject to approval by the Division
2) Receive re-education on the Division's standards, policy and procedures on Medication Assistance,
3) Train or retrain personnel as needed to safely assist participant's with medication, and
4) Address the areas of non-compliance within the timeline specified by the Division and always before the next recertification is completed.

Frequency of Monitoring:
BHD monitors provider compliance in various frequencies depending on the type of monitoring. Monitoring will occur at team meetings attended by BHD staff, but frequency depends on staff availability for attendance. Monitoring occurs annually through annual review of the plan of care by BHD. BHD also monitors provider compliance with medication management at least every two years, depending on provider recertification dates. During the certification/recertification process, a statistically valid sample of the number of the waiver participants served at the time of monitoring will be used.

Secondly, the ratio of those needing medication assistance to the total sample will be used to estimate the universe of those requiring medication assistance. Then a statistical sample of participants requiring med assist will be reviewed. The records reviewed are listed in the
next paragraph.

BHD is responsible for monitoring provider compliance with the BHD's medication assistance policy and standards. The BHD reviews a sample of 1) provider personnel files to ensure qualified persons are assisting participants with medications, and
2) provider's participant files who receive medication assistance.

Sampling and process:
1) BHD maintains a registry for all providers and provider personnel who have completed the Medication Assistance curriculum requirements. During an initial certification or a recertification of a provider, which occurs at least every two years, the BHD reviews the provider's training records for persons who are Approved Medication Assistants. A statistically valid sample of Approved Medication Assistant personnel employed by a provider are reviewed based upon the number of persons trained for that provider according to the BHD's registry.

2) The plan of care describes the type of assistance a participant needs. BHD reviews a representative sample waiver participant files biennially to verify if the participant is receiving the monitoring, medication management, and assistance with medication in a healthy and safe manner according to his/her plan of care and State standards. The representative sample size has a 95% confidence level and a margin of error of 5%. The sample is identified at the beginning of each two year cycle and the review of the implementation of the plans of care is completed throughout two fiscal years. In addition to the review of implementation of plans of care, BHD reviews case management documentation of the participants in the sample for a six-month period to verify the case manager is consistently monitoring medication assistance, including completing follow-up when concerns are found and updating the plan as needed. The representative sample size has a 95% confidence level and a margin of error of 5%.

The results of this monitoring activities will be maintained in IMPROV, to identify trends and make changes as needed in this area. Changes could include enhancing the training modules for Approved Medication Assistants, increasing monitoring activities to assure compliance with the standards, and/or releasing general bulletins in specific areas to remind providers of the standards.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*

a. Methods for Discovery: Health and Welfare

The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare. *(For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")*

i. Sub-Assurances:

a. ***Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instancesof abuse, neglect, exploitation and unexplained death.*** *(Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
25 Percentage of participant and guardians who verify in the annual plan of care they have received training on their rights, and recognizing and reporting instances of abuse, neglect, and exploitation (the number of verified signatures on this question submitted with the annual plan of care divided by the number of plans received)

Data Source (Select one):
Analyzed collected data (including surveys, focus group, interviews, etc)
If 'Other' is selected, specify:
EMWS

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
26 The number of critical incidents that resulted in Division follow up, provider corrective action plans, sanctions, or other disciplinary action (the number of critical incidents reviewed and followed up according to state requirements divided by the number of incidents received)

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:
IMPROV

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Other** Specify:

Performance Measure:
27 # and type of deaths with possible provider concerns determined by the mortality review committee that result in a provider corrective action, sanction, or other disciplinary action and a resolution status (# of deaths resulting in provider corrective action, sanction, or other disciplinary action and the resolution status of action taken / # of deaths found to have possible provider concerns)

Data Source (Select one):
Mortality reviews
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis *(check each that applies):*

28 The number of incidents regarding abuse, neglect, exploitation and unexplained death that were addressed according to state regulations (the number of abuse, neglect, exploitation, and unexplained death incidents addressed by category of follow up and resolution divided by the number received)

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: aggregation of data occurs over two year period but a report is generated annually

Performance Measure:
29 The number and type of restrictions and restraints reported to the Division that are found to have followed the state rules and procedures (the number and type of restrictions and restraints reported and listing follow up action correctly divided by the number of restrictions and restaints reported)

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:
IMPROV

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis *(check each that applies):*	
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
30 Percentage of participants who are receiving preventive medical care according to the state standard (the number of participants whose plan notes dates for preventive medical care appointments as specified in state standards divided by the number of plans received)

Data Source (Select one):
Other
If 'Other' is selected, specify:
EMWS

Responsible Party for data collection/generation *(check each that applies):*	Frequency of data collection/generation *(check each that applies):*	Sampling Approach *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis *(check each that applies):*	
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

c. ***Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

d. ***Sub-assurance: The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

Responsible Party(check each that applies):	Frequency of data aggregation and analysis(check each that applies):

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

Methods of Discovery - Health and Welfare:
Critical incidents are sent to the BHD via the BHD website. These incidents are automatically recorded in the Division's electronic provider management system, IMPROV. All providers are also required to send a copy of the critical incident to the guardian, case manager, DFS, and Protection and Advocacy. BHD staff are responsible for assigning a category for the incident depending on the severity and what it entails. DFS and Protection and Advocacy review all critical incidents that are filed and complete full investigations when it is suspected that abuse, neglect, or exploitation might have occurred, or when restriction of rights might have been violated.

Providers are also required to report to the Division any restraint that results in an injury using the same website. Injuries that are a result of a restraint must also be reported to DFS, Protection and Advocacy, the guardian, and the case manager. If a restraint is used on a participant that does not result in an injury, it still must be reported to the Division at the same website; however, this does not need to be reported to DFS or Protection and Advocacy. This includes any emergency restraints that are used on a participant. Division staff are responsible for reviewing all restraint usage to ensure provider compliance.

Medication errors must be reported to the Division so that the Division can provide the required re-training to providers. These errors need to be reported to the Division at the same website but do not need to be reported to DFS or Protection and Advocacy unless they meet the category of a critical incident. Division staff are responsible for reviewing all instances of medication errors for provider compliance. When Division staff identify individual problems concerning health, safety and rights are discovered through an incident report or complaint, providers receive a "recommendation" from the Division. A recommendation identifies the specific area of non-compliance and providers are required to submit a corrective action plan within a specified time frame to address the area of non-compliance. All recommendations and any follow up completed by the Division are documented in IMPROV. The corrective action plan must include specific action steps, responsible parties, and time frames for completing each action step. The corrective action plan template is on the BHD's website at http://health.wyo.gov/ddd/ddd/carfpiforms.html and providers can go to the website if they need assistance with writing a corrective action plan, or they can contact the Division for more clarification and guidance. The corrective action plan must be submitted to the BHD within 15 business days if the recommendation identified concerns with health, safety or rights, and within 30 calendar days otherwise. The BHD must review and approve the corrective action plan for each recommendation. The BHD must also monitor the implementation of the corrective action plan to assure the area of non-compliance has been addressed. This monitoring may include on-site visits, review of documentation, and interviews with providers, provider staff, participants, guardians and/or case managers. The type of monitoring completed depends on the type of non-compliance and severity of the situation. In addition, all recommendations are reviewed by the Division during the provider's next recertification to assure the area of non-compliance continues to be addressed.

If a provider fails to submit an acceptable corrective action plan after several attempts working with the BHD, the BHD can impose a sanction. Sanctions include suspending admissions, suspending the provider, decertifying the provider, requiring additional training, imposing civil monetary penalties, and/or imposing a monitor within the provider organization. When providers receive a recommendation, which can occur through the recertification process, complaint process, or incident reporting process, the information is entered into the BHD's provider management system (IMPROV). IMPROV is a web based system that automatically tracks the category of recommendation, due date for the provider to submit the corrective action plan for each recommendation, and the status of the recommendation. IMPROV includes letters/information sent to the provider identifying the area of non-compliance and the results of the review of the corrective action plan. Overdue corrective action plans are listed as "overdue" in a work queue that both the Provider Support Specialist and Manager have access. This process assures the BHD is able to track the status of all corrective action plans.

The BHD Provider Support Manager reviews the status of corrective action plans on a weekly basis, and completes a quality assurance check within IMPROV to assure staff have entered the information on the corrective action plan into IMPROV, have sent the appropriate notifications, have reviewed the submitted corrective action plans, and are monitoring the implementation of the plan.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Health and Welfare that are currently non-operational.

- **No**
- **Yes**

Please provide a detailed strategy for assuring Health and Welfare, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix H: Quality Improvement Strategy (1 of 2)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the State has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the State specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the State is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances;
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances;

In Appendix H of the application, a State describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the State's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the State plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid State plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the State must be able to stratify information that is related to each approved waiver program. Unless the State has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the State must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 2)

H-1: Systems Improvement

a. System Improvements

i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

Responsible Party*(check each that applies):* **Frequency of Monitoring and Analysis***(check each that applies):*

The BHD has a variety of processes that generate information or collect data to evaluate waiver performance. These processes and the assurance categories that they encompass are:
1. Waiver Applicant Process: Level of Care. Eligibility assessments and determination of eligibility. Data collected in EMWS.
2. Plan of Care Development: Division attendance at initial team meetings for new applicants and others by request, education to applicants and families on the waiver system, participant or guardian and case manager roles and responsibilities.
3. Plan of Care Approval: Service Plan, Qualified Providers, Health and Welfare. Data collected in EMWS.
4. Extraordinary Care Review: Service Plan, Qualified Providers, Health and Welfare, Financial Accountability. Data collected in Extraordinary Care Committee Database.
5. Provider Recertification: Service Plan, Qualified Providers, Health and Welfare, Administrative Authority, Financial Accountability. Data collected in IMPROV.
6. Complaint Process: Service Plan, Qualified Providers, Health and Welfare, Financial Accountability. Data collected in IMPROV.
7. Incident Reporting: Service Plan, Qualified Providers, Health and Welfare, Financial Accountability. Data collected in IMPROV.
8. Satisfaction Surveys: Service Plan, Qualified Providers, Health and Welfare, Financial Accountability. Data collected in Participant Case Review Database
9. Mortality Review: Service Plan, Qualified Providers, Health and Welfare, Administrative Authority, Financial Accountability. Data collected in Mortality Review Database.
10. Representative Sample review of participant cases: Service Plan, Qualified Providers, Health and Welfare, Financial Accountability.
11. Utilization review process: service plan, financial authority, qualified provider and administrative authority.

While many of the process involve data collection by the BHD, an effort is underway to partner with other entities that are already collecting information so that effort is not duplicated.

Each year as the 372(S) report is being completed, the assurances will be reviewed. The results of the review will be noted on the QIS portion of the 372(S) report. Changes in indicators, new data measurement or discontinuance of indicators due to demonstrated ongoing goal compliance will be noted.

ii. System Improvement Activities

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Quality Improvement Committee**	☑ **Annually**
☑ **Other** Specify: BHD DD Advisory Council	☐ **Other** Specify:

b. System Design Changes

i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the State's targeted standards for systems improvement.

System design changes may be identified during the quarterly review of the performance measures or during the annual trend analysis completed in conjunction with the BHD's Advisory Council, both described in Section H-1-a. Once system design changes have been agreed upon, the BHD with the State Medicaid Agent identifies the following:
- Who will oversee the systems change, which depends on the assurances impacted by the change
  - The State Medicaid Agent or designee takes the lead on the changes impacting Administrative Authority and/or Financial Accountability
  - The BHD takes the lead on changes impacting Level of Care, Service Plan, Qualified Providers, and Health and Welfare
- Identification of other agencies or stakeholders who should be involved in system design changes
- Major action steps to implement the change
- The timeline for the change, including time lines for each major action step
- Identification of performance measures and appropriate data collection to track the results of the systems change
- Timeline for assessing impact of change

BHD, the Medicaid Waiver Liaison, and the Medicaid Program Integrity Manager review implementation of systems changes quarterly to review process on the system changes, to identify potential barriers, and to make changes as needed to the action plan to implement system changes. The BHD-DD Advisory Council is updated semi-annually on the implementation of the system improvements through a written report and formal presentation.

The Division will use the proportionate stratified sampling method to maintain a cost-effective sample size while ensuring each waiver sub-populations (Supports, Adult DD, Child DD and ABI Waivers) are represented in survey data. The sample would be completed over two (2) years as is done currently.

BHD continues to maintain the 95% confidence level for its waiver population with this change; there is less than 2% change within the 5% margin of error using the proportionate stratified sampling method. To gain 2% accuracy while doubling the sample size is not cost effective or fiscally responsible.

ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

The BHD presents information on the effectiveness of the quality improvement strategy, including the effectiveness of the performance measures, processes used by the BHD to gather data, changes to databases or data analysis, and issues with data reliability, annually to the BHD's DD Section Advisory Council. The BHD DD Section Advisory Council makes recommendations on changes to the quality improvement system, and the BHD works with the State Medicaid Agent to identify appropriate changes based on these recommendations. A timeline is developed to implement changes that includes responsible parties, action steps, and deadlines for each major step. The BHD's DD Section Advisory Council is updated on the progress of the changes, and the changes are reported to CMS in an annual report.

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

(a) As stated in Wyoming Medicaid Rules, Chapter 45, Waiver providers who are required to obtain CARF accreditation must have an annual independent financial audit. The audit is submitted to the State Medicaid Agency each year. Providers who have three or more people in Residential Habilitation, Day Habilitation, Supported Living, Community Integration, Prevocational or Supported Employment and make more than $125,000 a year on plans of care are required to obtain and maintain CARF accreditation.

(b & c) The waiver, through the SMA, is part of the annual State Financial Audit which is conducted every year by an external accounting group, McGee, Hearne & Paiz. The audit always includes a sample of waiver claims. The audit includes the entire process of Medicaid from eligibility all the through to final payment including the process with payment from CMS. The sample is determined by Medicaid Program Integrity's contractor for the audit. It is a random statistically valid sample with a 95% confidence interval and a =/-5% margin of error.

The state uses Medicaid Integrity Contractors (MICs), which are private companies that conduct audit-related activities under contract to the Medicaid Integrity Group (MIG), the component within CMS that is charged by the U.S. Department of Health & Human Services with carrying out the Medicaid Integrity Program. The Review MICs run MIG-approved algorithms on claims data from the Medicaid Statistical Information System (MSIS). The MIG's Division of Fraud Research & Detection reviews and approves those results before they are provided to the Audit MICs for audit. The MIG vets providers to be audited with State Medicaid agencies prior to the start of the audits. The MIG also shares the list of potential audits with State and Federal law enforcement agencies. If either a State Medicaid agency or a law enforcement agency is conducting an audit or investigation of the same provider for similar Medicaid issues, then the MIG may cancel or postpone the Audit MIC audit of the provider.

Medicaid's Program Integrity Unit reviews a random statistically valid sample of provider waiver claims. The auditing of claims is done by random selection as well as targeted claims which meet certain criteria. The auditing process is done on a periodic basis for utilization review and quality assurance purposes. The Wyoming policies for Medicaid's Program Integrity Unit are outlined in Wyoming Medicaid Rules (Chapters 4 and 16). Medicaid also participates in the Payment Error Reporting Measurement (PERM) program to ensure accuracy of the claims reimbursement process.

Providers are required to submit all documentation of services within an identified time period. If it is found that documentation is not complete, re-education or recoveries will be completed. Any concerns with documentation are reported to Medicaid's Case Utilization Review Team (CURT), which includes representation from the Behavioral Health Division, as well as Medicaid Fraud. The committee determines the appropriate response to the documentation concerns, which can include re-education of the provider, recovery of funds, and/or referral to the Medicaid Fraud Control Unit.

Waiver claims are included in the Explanation of Medical Benefits (EOMB) sample sent to participants. This random sample of participants requests the participant verify that the services listed on the EOMB were actually received by them. Responses to the EOMB that indicate services were not received, are reviewed by the Case Utilization Review Team (CURT).

The Division's Provider Support Unit also does a documentation review for each provider during the recertification process, and if a complaint or referral is submitted relating to documentation or claims concerns. Results of the documentation reviewed are recorded in IMPROV if concerns are found, and referrals to Medicaid Program Integrity and/or Medicaid Fraud Control Unit are recorded in IMPROV as needed. Reviews and on-site visits may include, but are not limited to:
- Examination of records
- Interviews of providers, associates, and employees
- Interviews of program clients
- Verification of the professional credentials of providers, their associates, and their employees
- Examination of any equipment, stock, materials and other items used in or for the treatment of clients in the program
- Audit of facility financial records for reimbursement
- Determination of whether the health care provided is medically necessary and/or
- Random sampling of claims submitted by and payments made to providers

Also BHD, in conjunction with the Medicaid Program Integrity Unit, developed a process for monitoring the Financial Management Service Fiscal/Employer Agent, including a process to audit claims submitted by the agent, as outlined in Appendix E.

Rules outlining the states required oversight are in Wyoming Medicaid Rules, Chapter 3 (Provider Participation), Chapter 4 (Administrative Hearings), Chapter 45, Provider Certification Standards and Sanctions

BHD through recertification or complaints refers to the Medicaid agency and Medicaid Fraud Control Unit any suspected concerns with providing billing.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Financial Accountability

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis*(check each that applies):*

State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver. *(For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")*

i. Sub-Assurances:

a. ***Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.*** *(Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
31 Number and percent of claims that are paid in accordance with the approved waiver (number of claims coded and paid per services approved in the plan of care and according to the rate methodology in the approved waiver divided by claims paid)

Data Source (Select one):
Other
If 'Other' is selected, specify:
MMIS Report

Responsible Party for data collection/generation*(check each that applies):*	Frequency of data collection/generation*(check each that applies):*	Sampling Approach*(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis*(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis*(check each that applies):*
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
32 Number and percent of provider payment rates that are consistent with rate methodology approved in the approved waiver application or subsequent amendment (the number of payments consistent with approved waiver rate methodology divided by claims paid)

Data Source (Select one):
Other
If 'Other' is selected, specify:
MMIS report and EMWS report

Responsible Party for data collection/generation*(check each that applies):*	Frequency of data collection/generation*(check each that applies):*	Sampling Approach*(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis*(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Responsible Party *(check each that applies):*	Frequency of data aggregation and analysis *(check each that applies):*

b. *Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

The BHD's re-certification process and complaint process can identify billing errors or potential fraud, as can routine investigative techniques used by the Medicaid Program Integrity Unit. Referrals can be made from the BHD to the Medicaid Program Integrity Unit or Medicaid Fraud Control Unit for investigation. The status of recoveries and investigations is discussed at monthly CURT (Core Utilization Review Team) held by the Medicaid Program Integrity Unit.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

If the identified problem is related to service plans or prior authorization, the BHD would investigate how the error occurred and correct it. If the error involved the part of prior authorization that is done by the MMIS Contractor, the MMIS Contract Manager would be included in the resolution. The Division would also investigate if the problem was an isolated incident or had occurred more than once, which might indicate the need for a system change. Any claims paid in error would be recovered. If the identified problem related to rates, the BHD would investigate how the error occurred and correct it. If the error involved something that is done by the MMIS Contractor, the MMIS Contract Manager would be involved in the resolution. The Division would also investigate if the problem was an isolated incident or had occurred more than once, which might indicate the need for a system change. Any claims paid in error would be recovered. If the identified problem was related to provider certification, the BHD would investigate how the error occurred and correct it. If the error involved the part of provider enrollment that is done by the MMIS contractor, the MMIS Contract Manager would be involved in the resolution. BHD would also investigate if the problem was an isolated incident or had occurred more than once, which might indicate the need for a system change. Any claims paid in error would be recovered. In general, when a problem with a claim is identified by BHD, they may offer additional education or refer the case to the Medicaid Program Integrity Unit of Medicaid Fraud Control Unit for possible recovery of funds and/or investigation for fraud. If preliminary investigation by the Medicaid Program Integrity Unit shows that the concern was unintentional on the part of the provider, provider education is given. Provider education needed due to poor documentation is done by the BHD. Provider education needed due to a billing problem is done by the Program Integrity Unit and/or the Provider Relations section of the MMIS contractor. Additionally, if provider documentation is found to be inadequate, funds paid to the provider are recovered by the Medicaid Program Integrity Unit. If preliminary investigation by the Medicaid Program Integrity Unit raises suspicion of fraud or abuse by a provider, the Program Integrity Manager refers the case to the Medicaid Fraud and Control Unit for further investigation. Recoveries and investigations will be tracked through E-FADS, an enhancement to the Program Integrity Unit's tracking system.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party *(check each that applies):*	Frequency of data aggregation and analysis *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Financial Accountability, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

a. Rate Determination Methods. In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

BHD objectives for rate determination:
- Rate standardization and equity

Current rates are standardized and based on a variety of factors, including provider costs, average wages for similar services as collected by the Dept of Labor, incentive factors for provider shortage areas, difficulty of care, equity and portability of payment based upon individual need, and outcome requirements. Rates are consistent for similar services, regardless of which provider is providing the service.
- Reflect participant needs

The rates provide sufficient definition to reflect participant need as measured by the Inventory for Client and Agency Planning (ICAP) assessment. Payments for waiver services will be consistent with efficiency, economy and quality of care and will be sufficient to enlist enough providers.
- Facilitate regular updates

The methods and data used to establish rates are formula-driven, which should facilitate increases and decreases to rates in future periods.
- Increased transparency

Information about payment rates is made available to participants, guardians and providers by posting the rates on the BHD website and distributing notices electronically to providers.
- Fiscal stability for providers and the state

The rate methodology is prospective in nature, and rates should be known in advance of services being provided. Enhanced predictability will allow for providers to better manage the costs of their operations. It will also allow the State to more easily project and budget for appropriate funding levels for waiver services.

Background on rate development
In 2007 and 2011, Navigant Consulting assisted BHD in a provider cost study to determine the costs incurred by providers to provide specific waiver services. Part of the current rate methodology uses Wyoming provider-reported costs. As the waivers were being renewed in 2013, the Division utilized Myers and Stauffer (consultant) to review Wyoming's waiver rate structure and compare them to other waiver rate structures in other states providing similar services.

In 2008, BHD was required by state statute (W.S. 42-4-120 (g)) to establish by rule and regulation a cost based reimbursement system to pay providers of services and supplies under home and community based waiver programs for persons with developmental disabilities or acquired brain injury.

Based on the rate determination objectives, BHD used the standardized rates for waiver services developed in 2008, which have received legislative decreases and increases since that time.

When the rates were initially developed, the consulting firm used an independent rate model development approach that incorporates data related to wages, overhead, productivity, staffing ratios and other factors to create a proposed rate for each service and service level (for most tiered habilitation rates). The assumptions made for each proposed rate are based on data reported by the HCBS providers in Wyoming through a cost and wage survey process, and through other public sources of cost information. The standardized rates established for services under this approach achieved all of the objectives described above.

IBA methodology
The determination of funding for individuals is determined using an assessment process involving information from the ICAP. This comprehensive assessment requires an objective assessment of each person's functional abilities, maladaptive behaviors, living placement, behavioral and health factors. Funding is assigned based on this information to provide for equitable distribution of funding based on each person' assessed needs. Data from this assessment are entered into a formula to determine the funding amount for the day or residential services. The use of this formula ensures consistent funding based on the abilities of the individual, independent of the provider. Thus, it is an individualized budget that allows the person to choose their provider and to receive the same level of support in terms of units of services, regardless of which provider they live with. If they live with family, independently or semi-independently, the IBA is adjusted to reflect that living situation. Funding amounts are determined for persons new to services, prior to certain transitions, or when they have a significant change in supports or abilities that put the person at risk.

Rate Components Considered
- Direct Care Staff Compensation: Two primary job classes were used from these compensation studies. Job classifications used for Personal Support Workers are staff who perform typical duties of a developmental disabilities attendant with a high school degree and no special training. Job classifications used for Habilitation Workers are staff who perform the duties of an ABI attendant with an Associate's degree, CNA, or special training.
- Employee Expenses: Employment related expenditures refer to the benefits package that is offered to all employees who are involved in the care and services provided to the waiver participant and are divided into two groups. Discretionary costs are those associated with benefits provided at the discretion of the employer and are not mandated by local, state, or federal governments. Non-discretionary costs are those related to employment expenditures mandated by local, State, and Federal governments and are not optional to the employer.
- Program Supervision and Indirect Expenses: Expenses that are part of the operation of the setting in which residential habilitation occurs and related to the programs which occur within the setting, but are not directly tied to the direct care staff. They include program management and clinical staff costs as well as program operational expenses.
- General and Administrative Expenses: Expenses associated with operating the organization's business and administration and are not directly related to the participants or the programs that serve the participants.
- Level of Service need: Using the ICAP, a person is assessed to assign a tiered level of service reimbursement for habilitation services such as residential habilitation, community integration, and prevocational services.

Rate Structure Description:
- Component #1 - Direct provider time as the billable unit:
  - The time the provider spends with the participant and family to provide the services, which meet the participant's chosen objective. The tiered level of service need also factors into this rate component.
- Component #2 - Standardized Costs for the service provided:
  - Review the customary cost for the service compared to other waiver programs and similar professions that require specialized training, with a small incentive factor to sustain provider enrollment for certain services, such as employment and skilled nursing. Employment related expenditures, including benefits, overhead, supervision, materials, office, travel, and training.
- Component #3 - Other Factors:
  - Historical expenditures of providers by service type, frequency, and an examination of reported shortage areas by participants and families.

Rates by service type
- The rate for intermittent services, such as supported living, community integration, prevocational, supported employment, companion services, and personal care are paid for each 15 minute unit staff time involved in direct habilitation or support of individual(s) in services based upon the care being provided. This intermittent rate reimbursement is based on the starting salary for Direct Support Professionals as reported in provider cost studies and similar professions in the state, and it includes allowances for direct support staff salaries and benefits, salaries and benefits of supervisors of direct support staff, transportation services to and from facilities and locations for persons for the purpose of receiving other waiver or state plan services, management and overhead costs. Supported employment and Supported living 15 minute do not have transportation costs built in.

- Continuous services are residential habilitation services provided in a provider operated setting where there are provider staff on-site and immediately available at all times to the individual receiving services, including during the individual's

sleep time. Rate reimbursement is based on the starting salary for Direct Support Professionals as reported in provider cost studies and similar professions in the state, and it includes allowances for direct support staff salaries and benefits, salaries and benefits of supervisors of direct support staff, transportation services to and from facilities and locations for persons for the purpose of receiving other waiver or state plan services, management and overhead costs. The individual's daily rate for continuous services provided by a single provider is determined by a tiered level of the service based upon the participant's assessed level of service need and budgeting the IBA for 365 days of service (and 366 for leap years).

• Behavioral Support Services is a cost adjusted rate per case and includes professional staff salaries, benefits, and preparation time to review information and schedule the site visit; travel time; on-site time, which includes a preliminary meeting, and observing the individual in various settings. The rate of this service is adjusted per case and all approvals for the service are reviewed annually for costs, outcomes, and adjustments needed.

• The authorized annual funding for self-directed goods and services, specialized equipment and environmental modifications is approved on a per case basis using either average costs for the service delivered or a three-bid quote review in order to approve needed services in a cost effective manner. Costs for services requested and approved and service cap limits are reviewed annually.

• In Self-Directed Services, the participant does not utilize the provider-managed rate methodology. Instead, s/he pay staff within a wage range. The cost to the participant's IBA is the wage, which includes employer payroll taxes, state and federal unemployment taxes. The participant may increase the wage to assist with employee medical benefits. The wage minimum is based upon the federal minimum wage and the wage maximum is based upon the 90th percentile wage as of March 2009 per the Wy. Dept of Employment, by type of service. Wage ranges for services provided in a group setting are adjusted by the assumed staffing ratio.
• Transportation reimbursement is based on the federal standard for mileage reimbursement as of July 2013, which was $.56.

Rate Review
Rate determination methods and rates are reviewed and approved by the state Medicaid agency. In addition to the public process described above, BHD also solicits public comments by means of a public notice when changes in methods and standards for establishing payment rates under the Waiver are proposed. The notice is published in accordance with federal requirements at 42 CFR 447.205, which prescribes the content and publication criteria for the notice. Whenever rates change, BHD makes listings of all covered services and corresponding rates available to clients and their families and service providers.

Information on payment rates are available to participants as part of the regular team meetings, are posted on BHD's website and are available upon request.

b. Flow of Billings. Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the State's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

The Wyoming Medicaid Management Information System (MMIS) is the system used to accept and process claims for services rendered by the Waiver providers. Providers will directly submit electronic claims using an electronic software system or via web online entry, which are both direct input tools to the Wyoming MMIS. Once a provider submits a claim, the claim enters the MMIS and is processed through the processing cycle, which includes all edits and audits.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

c. Certifying Public Expenditures *(select one)*:

- (◉) **No. State or local government agencies do not certify expenditures for waiver services.**
- ( ) **Yes. State or local government agencies directly expend funds for part or all of the cost of waiver services and certify their State government expenditures (CPE) in lieu of billing that amount to Medicaid.**

***Select at least one*:**

- [ ] **Certified Public Expenditures (CPE) of State Public Agencies.**

  Specify: (a) the State government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b).*(Indicate source of revenue for CPEs in Item I-4-a.)*

- [ ] **Certified Public Expenditures (CPE) of Local Government Agencies.**

  Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). *(Indicate source of revenue for CPEs in Item I-4-b.)*

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

d. Billing Validation Process. Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

All service requests through traditional service delivery are reviewed and prior authorized by BHD staff, who review the service descriptions, units, rates, and quantity to see that the total amount of services requested is within the IBA and that services align with assessed need. The specialist verifies the provider is certified for the requested service and that the units requested do not exceed the specified methodology. All traditional services must receive a prior authorization number that is assigned through the MMIS. All billing for waiver services is submitted electronically through MMIS and all providers are paid through that system. There are many edits built into the MMIS that do not allow payment for more units or dollar requests above the amount approved. System edits include service codes with set rates, limits on number of days that can be billed in a month, number of hours that can be billed in a day, and other time specific rules which limit the amount of services that can be billed. Since all claims are submitted electronically using a Prior Authorization number, the MMIS utilizes edits to assure that payments never exceed authorization. No traditional waiver services are authorized without a Prior Authorization number.

Self-Directed Services are reviewed and approved by BHD staff prior to the self-direction budget being approved and authorized in the Fiscal Employer Agent web-based system. Claims to the FMS are paid through MMIS.

An individual must be an active Medicaid recipient enrolled in the Waiver program in order for services to be processed and paid for. This assurance is an integral component managed by the Wyoming Medicaid Management Information System (MMIS).

The MMIS requires an individual to be:
- Enrolled in Medicaid
- Enrolled in a Waiver program
Additional checks regarding services rendered, including appropriate provider type, no duplicate claims submitted, etc. are also performed.

The Wyoming Claims Processing Subsystem uses a Recipient Master File to verify recipient eligibility for services billed by a provider. Once an individual becomes eligible for services, the participant's eligibility information is updated in the MMIS. Only services in the client's plan will be covered based on limits established by the prior authorization number assigned to the service. The MMIS posts exceptions if a recipient is not eligible on the service date or is restricted from the service (as indicated in the service restrictions on the Recipient Master File). Service restrictions may include restricting the recipient to a particular provider for treatment or placing the recipient on review.

The MMIS checks other service limitations by referencing recipient Medicaid eligibility, TPL, and by various benefit plan specific limits established by the Utilization Review (UR) Criteria File. Each claim processed by the Wyoming Claims Processing cycle (regardless of the entry method) has to pass the provider eligibility edit module. The Provider Master File verifies that the provider is actively enrolled and licensed according to the benefit plan for the category of service and dates of service. It also verifies any special restrictions for the provider for the service date on the claim. For each test that fails, the MMIS posts an exception code. The claim is adjudicated according to the exception disposition codes maintained on the Exception Control File.

The Claims Processing Subsystem also uses several edits to verify the reasonableness of provider charges. First the system performs internal balancing of claim charges. Second, the system edits and checks each service charge against pricing information on the reference files. Medicaid determines the disposition of the exception codes posting to claims and the system maintains this information on line in the Exception Code File. The Claims Processing Subsystem has the capability of allowing the force payment of services on an exceptional basis, as directed in writing by Medicaid. Through the life of a claim, the system retains in the claim record all exception codes posting to the claim, the adjudication ID of the person who forced or denied any exceptions to the claim, and the date and adjudication ID of the last person who worked on the claim. These features provide an audit trail to support the claim's payment process.

e. Billing and Claims Record Maintenance Requirement. Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

a. Method of payments -- MMIS (*select one*):

- (●) **Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).**
- ( ) **Payments for some, but not all, waiver services are made through an approved MMIS.**

  Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- ( ) **Payments for waiver services are not made through an approved MMIS.**

  Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- ( ) **Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.**

  Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

b. Direct payment. In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (*select at least one*):

- ☐ **The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.**
- ☑ **The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.**
- ☐ **The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.**

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

- ☐ **Providers are paid by a managed care entity or entities for services that are included in the State's contract with the entity.**

Specify how providers are paid for the services (if any) not included in the State's contract with managed care entities.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

c. Supplemental or Enhanced Payments. Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan/waiver. Specify whether supplemental or enhanced payments are made. *Select one:*

- ◉ **No. The State does not make supplemental or enhanced payments for waiver services.**
- ○ **Yes. The State makes supplemental or enhanced payments for waiver services.**

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the State to CMS. Upon request, the State will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. Payments to State or Local Government Providers. *Specify whether State or local government providers receive payment for the provision of waiver services.*

- ◉ **No. State or local government providers do not receive payment for waiver services.** Do not complete Item I-3-e.
- ○ **Yes. State or local government providers receive payment for waiver services.** Complete Item I-3-e.

Specify the types of State or local government providers that receive payment for waiver services and the services that the State or local government providers furnish:

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the State recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. *Select one:*

Answers provided in Appendix I-3-d indicate that you do not need to complete this section.

- ○ **The amount paid to State or local government providers is the same as the amount paid to private providers of the same service.**
- ○ **The amount paid to State or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.**
- ○ **The amount paid to State or local government providers differs from the amount paid to private providers of the same service. When a State or local government provider receives payments (including regular and any supplemental**

payments) that in the aggregate exceed the cost of waiver services, the State recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. *Select one:*

- **Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.**
- **Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.**

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the State.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

- **No. The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.**
- **Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).**

Specify the governmental agency (or agencies) to which reassignment may be made.

ii. Organized Health Care Delivery System. *Select one:*

- **No. The State does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.**
- **Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.**

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

iii. Contracts with MCOs, PIHPs or PAHPs. *Select one:*

- **The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.**
- **The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency.**

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

- **This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.**

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the State source or sources of the non-federal share of computable waiver costs. *Select at least one*:

- [x] **Appropriation of State Tax Revenues to the State Medicaid agency**
- [ ] **Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.**

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the State entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

- [ ] **Other State Level Source(s) of Funds.**

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. *Select One*:

- (•) **Not Applicable**. There are no local government level sources of funds utilized as the non-federal share.
- ( ) **Applicable**

Check each that applies:

- [ ] **Appropriation of Local Government Revenues.**

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

- [ ] **Other Local Government Level Source(s) of Funds.**

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the State Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. Information Concerning Certain Sources of Funds. Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. *Select one*:

- (•) **None of the specified sources of funds contribute to the non-federal share of computable waiver costs**
- ( ) **The following source(s) are used**

Check each that applies:

- [ ] **Health care-related taxes or fees**
- [ ] **Provider-related donations**
- [ ] **Federal funds**

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. Services Furnished in Residential Settings. *Select one:*

- ○ **No services under this waiver are furnished in residential settings other than the private residence of the individual.**
- ◉ **As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual.**

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. The following describes the methodology that the State uses to exclude Medicaid payment for room and board in residential settings:

Costs related to room and board for clients, as well as facility maintenance, upkeep and improvement related to residential program services are not covered by the ABI Waiver. These costs were excluded from the total costs collected for the rate determination and are therefore excluded from the payment rates. The payment rates are based solely on service costs.

The room and board costs were asked about during the provider cost studies to set the rates and when they were reevaluated, but captured as a separate item so the provider could not put them into administrative overhead or building maintenance. They are not a part of the rates for service and providers are reminded of this in the service definition and policy manual.

Providers do not submit annual cost reports though. The costs are evaluated when we rebase rates every 2-4 years.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

- ◉ **No. The State does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.**
- ○ **Yes. Per 42 CFR §441.310(a)(2)(ii), the State will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The State describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.**

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a. Co-Payment Requirements. Specify whether the State imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. *Select one:*

- ◉ **No. The State does not impose a co-payment or similar charge upon participants for waiver services.**
- ○ **Yes. The State imposes a co-payment or similar charge upon participants for one or more waiver services.**

i. Co-Pay Arrangement.

Specify the types of co-pay arrangements that are imposed on waiver participants (*check each that applies*):

Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

- ☐ **Nominal deductible**
- ☐ **Coinsurance**
- ☐ **Co-Payment**
- ☐ **Other charge**

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)

ii. Participants Subject to Co-pay Charges for Waiver Services.

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)
		Level of Care:
		ICF/IID

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. Specify whether the State imposes a premium, enrollment fee or similar cost sharing on waiver participants. *Select one*:

- **No. The State does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.**
- **Yes. The State imposes a premium, enrollment fee or similar cost-sharing arrangement.**

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.

Level(s) of Care: ICF/IID

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	36694.48	6692.00	43386.48	219407.00	830.00	220237.00	176850.52
2	36158.28	6692.00	42850.28	219407.00	830.00	220237.00	177386.72
3	37160.30	6692.00	43852.30	219407.00	830.00	220237.00	176384.70
4	37078.88	6692.00	43770.88	219407.00	830.00	220237.00	176466.12
5	37174.38	6692.00	43866.38	219407.00	830.00	220237.00	176370.62

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

a. Number Of Unduplicated Participants Served. Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

Table: J-2-a: Unduplicated Participants

Waiver Year Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a) Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable) Distribution of Unduplicated Participants by Level of Care (if applicable) Level of Care: ICF/IID
Year 1	240	240
Year 2	240	240
Year 3	240	240
Year 4	240	240
Year 5	240	240

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 9)

b. Average Length of Stay. Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.

The average length of stay estimate is calculated by taking the total number of days waiver recipients received waiver coverage during the waiver year divided by the number of unduplicated recipient count. Total days of waiver coverage = last-date-of-service - first-date-of-service + 1. If a recipient becomes institutionalized during the time of waiver coverage, those days are excluded from the calculation. The average length of stay reported in the SFY-2012 is used, based upon reports generated from the Medicaid Management Information System (MMIS), which is the report used to complete the CMS-372. The SFY-2012 MMIS data will be used for each year of the waiver.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

c. Derivation of Estimates for Each Factor. Provide a narrative description for the derivation of the estimates of the following factors.

i. Factor D Derivation. The estimates of Factor D for each waiver year are located in Item J-2-d. The basis for these estimates is as follows:

The Factor D is calculated by multiplying the estimated number of users/service by the units/user and cost/unit. This calculation results in a total estimated expenditure for each service. All of the estimated component costs are totaled to get a total estimated expenditure for the wavier. Finally, the total estimated figure is divided by the total number of unduplicated recipients to arrive at an average cost per recipient, Factor D. Factor D as reported in the SFY-2012 CMS 372 is being used for estimates for this waiver cycle. Data from the 372 comes from reports generated from the Medicaid Management Information system (MMIS). Additional changes to Factor D in the forthcoming waiver years are estimated as follows:

- Estimated number of users:
Step 1: Use the SFY-2012 MMIS report data.
Step 2: Adjust the total estimated unduplicated count for any additional participants due to additional funding provided to reduce the waiting list, if applicable.
Step 3: Apply a percentage of participants who utilize a service based upon prior service utilization.

- Estimated units/user:
Step 1: Use the SFY-2012 MMIS claims data to calculate the average units/user and round up to the next whole number.
Step 2: Convert any services that have a unit change from the SFY-2012 MMIS data, if applicable.
Step 3: Use estimates for new service utilization based on a percentage of other services going down, ie. former day habilitation numbers will be split into estimates for Community Integration Services, Adult Day Services and Prevocational.

- Estimated cost/unit:
Step 1: Use the published rates current to the waiver year.
Step 2: For those services that have multiply rates based upon level of care, calculate an average cost/unit/service.
Step 3: Apply an inflation/deflation factor to the cost/unit due to increases or decreases in funding provided for service rates by waiver year, if applicable.
Step 4: Convert any services that have a unit change from the SFY-2012 MMIS data, if applicable.
Step 5: For those services with an event unit, utilize the average paid amount in the SFY-2012 MMIS data.

ii. Factor D' Derivation. The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor D' is the estimated annual average per capita Medicaid cost for all services that are furnished in addition to waiver services while the individual is in the waiver.

Step 1: Use Factor D" reported in the SFY-2012 CMS-372

iii. Factor G Derivation. The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Waiver Service/Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost

value must reflect the average per capita cost for the level(s) of institutional care that would otherwise be furnished to waiver participants.

Step 1: Use the Factor G reported in the SFY-2012 CMS-372 report for each year, based upon reports generated from the MMIS.

iv. Factor G' Derivation. The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor G' includes the average per capita cost of all other Medicaid services furnished while the individual is institutionalized (including State plan services) and the cost of short term hospitalization (furnished with the expectation that the person would return to the institution).

Step 1: Use the Factor G'' reported in the SFY-2012 CMS-372 report for each year.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "*manage components*" to add these components.

Waiver Services	
Adult Day Services	
Case Management	
Community Integration Services	
Homemaker	
Personal Care	
Prevocational Services	
Residential Habilitation	
Respite	
Supported Employment	
Supported Living	
Occupational Therapy	
Physical Therapy	
Speech, Hearing and Language Services	
Independent Support Broker	
Behavioral Support Services	
Cognitive Retraining	
Companion Services	
Crisis Intervention Support	
Dietician Services	
Environmental Modifications	
Self-Directed Goods and Services	
Skilled Nursing	
Specialized Equipment	
Transportation	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 1

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Services Total:						**228825.00**
Basic Level	15 minute	23	1250.00	2.70	**77625.00**	

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Intermediate Level	15 minute	16	1250.00	3.51	70200.00	
High Level	15 minute	12	1250.00	5.40	81000.00	
Case Management Total:						507701.60
case management (monthly)	month	160	11.00	268.86	473193.60	
subsequent assessments	event	40	1.00	862.70	34508.00	
Community Integration Services Total:						838200.04
Community Integration Services (Basic)	15 minute	20	2500.00	2.97	148500.00	
day habilitation (daily) ending year 1	daily	0	0.00	0.01	0.00	
day habilitation intervention ending year 1	15 minute	50	0.00	0.01	0.00	
Community Integration Services (Intermediate)	15 minute	10	2000.00	3.86	77200.00	
Community Integration Services (High Level of Care)	15 minute	2	5000.00	5.94	59400.00	
day habilitation (High) ending year 1	Daily	4	300.00	97.41	116892.00	
day habilitation (Intensive) ending year 1	Daily	1	200.00	172.83	34566.00	
day habilitation (Intermittent) ending year 1	Daily	2	300.00	59.71	35826.00	
day habilitation (Moderate) ending year 1	Daily	2	194.00	72.28	28044.64	
Self Directed Day Habilitation	Self Directed	4	1.00	84442.85	337771.40	
Homemaker Total:						103019.85
Homemaker	15 minute	9	566.00	3.85	19611.90	
Self Directed	Self Directed	9	1.00	9267.55	83407.95	
Personal Care Total:						244248.38
Personal Care	15 minute	11	1507.72	3.85	63851.94	
Self Directed	Self Directed	4	1.00	45099.11	180396.44	
Prevocational Services Total:						145799.93
Prevocational (Basic Level)	15 minute	5	2000.00	2.70	27000.00	
Prevocational (Intermediate Level)	15 minute	11	1818.18	3.51	70199.93	
Prevocational (High Level)	15 minute	4	2250.00	5.40	48600.00	
Residential Habilitation Total:						3480464.25
Residential Habilitation (level 5)	Daily	20	344.15	187.50	1290562.50	

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Residential Habilitation (Level 6)	Daily	6	243.33	323.59	472434.93	
Residential Habilitation (Level 4)	Daily	17	313.88	142.00	757706.32	
Residential Habilitation (Level 3)	Daily	21	323.23	119.31	809856.00	
Residential Habilitation (Level 2)	Daily	2	400.00	88.77	71016.00	
Residential Habilitation (Level 1)	Daily	2	400.00	80.65	64520.00	
Intervention	15 minute	3	775.00	6.18	14368.50	
Respite Total:						130495.83
Respite Daily	daily	1	20.00	167.52	3350.40	
Respite - 15 minute	15 minute	8	1856.12	3.49	51822.87	
Self Directed	Self Directed	2	1.00	37661.28	75322.56	
Supported Employment Total:						231029.50
Individual Supported Employment	15 minute	11	727.27	6.78	54239.80	
Group Supported Employment	15 minute	9	2000.00	2.70	48600.00	
follow along	15 minute	15	600.00	6.78	61020.00	
Employment Discovery and Customization	15 minute	16	562.50	6.50	58500.00	
Self Directed	Self Directed	15	1.00	577.98	8669.70	
Supported Living Total:						1392312.47
Supported Living (group of 2 to 3 - 15 minute)	15 minute	6	4500.00	3.17	85590.00	
Supported Living (group daily)	daily	8	234.50	88.76	166513.76	
Supported Living (individual 15 minute)	15 minute	73	1570.50	8.27	948126.56	
Self Directed	Self Directed	13	1.00	14775.55	192082.15	
Occupational Therapy Total:						26981.18
Occupational/Physical Therapy group	session	2	30.00	15.96	957.60	
Occupational Therapy individual	15 minute	4	382.25	17.02	26023.58	
Physical Therapy Total:						29432.79
Physical Therapy (individual)	15 minute	6	235.50	20.83	29432.79	
Speech, Hearing and Language Services Total:						36870.04
Speech Hearing and Language Services (Individual)	session	6	101.00	50.34	30506.04	

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Speech Hearing and Language Services (Group)	session	2	100.00	19.32	3864.00	
Self Directed	Self Directed	8	1.00	312.50	2500.00	
Independent Support Broker Total:						202287.96
Independent Support Broker	15 minute	12	117.00	9.44	13253.76	
Self Directed	Self Directed	12	1.00	15752.85	189034.20	
Behavioral Support Services Total:						500.00
Behavioral Support Services	event	1	1.00	500.00	500.00	
Cognitive Retraining Total:						31037.40
Cognitive Retraining	15 minute	3	1290.00	8.02	31037.40	
Companion Services Total:						869675.92
Companion Services	15 minute	70	1730.93	3.85	466485.64	
Companion Services (group)	15 minute	1	576.00	1.93	1111.68	
Self Directed	Self Directed	20	1.00	20103.93	402078.60	
Crisis Intervention Support Total:						30900.06
Crisis Intervention Support	15 minute	3	1666.67	6.18	30900.06	
Dietician Services Total:						2980.64
Dietician Services	session	2	52.00	28.66	2980.64	
Environmental Modifications Total:						4646.24
Environmental Modifications (New)	event	2	1.00	2073.12	4146.24	
Environmental Modifications (Repair)	event	1	1.00	500.00	500.00	
Self-Directed Goods and Services Total:						0.00
Self-Directed Goods and Services	Self Directed	0	0.00	10658.00	0.00	
Skilled Nursing Total:						262749.24
Skilled Nursing	15 minute	39	272.00	18.01	191050.08	
Self Directed	Self Directed	39	1.00	1838.44	71699.16	
Specialized Equipment Total:						6517.90
Specialized Equipment (Repair)	event	2	1.00	362.00	724.00	
Specialized Equipment (New)	event	6	1.00	382.65	2295.90	
Self Directed	Self Directed	6	1.00	583.00	3498.00	
Transportation Total:						0.00

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Companion Services	event	0	0.00	0.56	0.00	
Self Directed	Self Directed	0	0.00	1.00	0.00	
				GRAND TOTAL:		8806676.21
				Total Estimated Unduplicated Participants:		240
				Factor D (Divide total by number of participants):		36694.48
				Average Length of Stay on the Waiver:		260

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 2

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Services Total:						558900.00
Basic Level	15 minute	92	1250.00	2.70	310500.00	
Intermediate Level	15 minute	32	1250.00	3.51	140400.00	
High Level	15 minute	16	1250.00	5.40	108000.00	
Case Management Total:						488722.20
case management (monthly)	month	160	11.00	268.86	473193.60	
subsequent assessments	event	18	1.00	862.70	15528.60	
Community Integration Services Total:						336430.75
Community Integration Services (Basic)	15 minute	70	909.10	2.97	189001.89	
day habilitation (daily) ending year 1	daily	0	0.00	0.01	0.00	
day habilitation intervention ending year 1	15 minute	0	0.00	6.18	0.00	
Community Integration Services (Intermediate)	15 minute	10	2000.00	3.86	77200.00	
Community Integration Services (High Level of Care)	15 minute	5	2000.00	5.94	59400.00	
day habilitation (High) ending year 1	Daily	0	0.00	97.41	0.00	
day habilitation (Intensive) ending year 1	Daily	0	0.00	172.83	0.00	
day habilitation (Intermittent) ending year 1	Daily	0	0.00	59.71	0.00	
day habilitation (Moderate) ending year 1	Daily	0	0.00	72.28	0.00	
Self Directed Day Habilitation	Self Directed	21	1.00	515.66	10828.86	
Homemaker Total:						103019.85

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Homemaker	15 minute	9	566.00	3.85	19611.90	
Self Directed	Self Directed	9	1.00	9267.55	83407.95	
Personal Care Total:						334447.09
Personal Care	15 minute	11	1507.73	3.85	63852.37	
Self Directed	Self Directed	11	1.00	24599.52	270594.72	
Prevocational Services Total:						145799.93
Prevocational (Basic Level)	15 minute	5	2000.00	2.70	27000.00	
Prevocational (Intermediate Level)	15 minute	11	1818.18	3.51	70199.93	
Prevocational (High Level)	15 minute	4	2250.00	5.40	48600.00	
Residential Habilitation Total:						3466120.80
Residential Habilitation (level 5)	daily	20	344.15	187.50	1290562.50	
Residential Habilitation (Level 6)	daily	6	243.33	323.59	472434.93	
Residential Habilitation (Level 4)	Daily	17	313.88	142.00	757706.32	
Residential Habilitation (Level 3)	Daily	21	323.24	119.31	809881.05	
Residential Habilitation (Level 2)	Daily	2	400.00	88.77	71016.00	
Residential Habilitation (Level 1)	Daily	2	400.00	80.65	64520.00	
Intervention	15 minute	0	0.00	6.41	0.00	
Respite Total:						130495.55
Respite Daily	daily	1	20.00	167.52	3350.40	
Respite - 15 minute	15 minute	8	1856.13	3.49	51823.15	
Self Directed	Self Directed	2	1.00	37661.00	75322.00	
Supported Employment Total:						231029.36
Individual Supported Employment	15 minute	15	533.33	6.78	54239.66	
Group Supported Employment	15 minute	10	1800.00	2.70	48600.00	
follow along	15 minute	2	4500.00	6.78	61020.00	
Employment Discovery and Customization	15 minute	8	1125.00	6.50	58500.00	
Self Directed	Self Directed	15	1.00	577.98	8669.70	
Supported Living Total:						1378047.33

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Supported Living (group of 2 to 3 - 15 minute)	15 minute	5	4500.00	3.17	71325.00	
Supported Living (group daily)	daily	8	234.50	88.76	166513.76	
Supported Living (individual 15 minute)	15 minute	73	1570.50	8.27	948126.56	
Self Directed	Self Directed	13	1.00	14775.54	192082.02	
Occupational Therapy Total:						13137.50
Occupational/Physical Therapy group	Session	2	25.00	15.96	798.00	
Occupational Therapy individual	15 minute	5	145.00	17.02	12339.50	
Physical Therapy Total:						29432.79
Physical Therapy (individual)	15 minute	6	235.50	20.83	29432.79	
Speech, Hearing and Language Services Total:						36870.04
Speech Hearing and Language Services (Individual)	15 min	6	101.00	50.34	30506.04	
Speech Hearing and Language Services (Group)	Session	2	100.00	19.32	3864.00	
Self Directed	Self Directed	8	1.00	312.50	2500.00	
Independent Support Broker Total:						202297.02
Independent Support Broker	15 minute	12	117.08	9.44	13262.82	
Self Directed	Self Directed	12	1.00	15752.85	189034.20	
Behavioral Support Services Total:						500.00
Behavioral Support Services	event	1	1.00	500.00	500.00	
Cognitive Retraining Total:						31037.40
Cognitive Retraining	15 minute	3	1290.00	8.02	31037.40	
Companion Services Total:						869675.52
Companion Services	15 minute	70	1730.93	3.85	466485.64	
Companion Services (group)	15 minute	1	576.00	1.93	1111.68	
Self Directed	Self Directed	20	1.00	20103.91	402078.20	
Crisis Intervention Support Total:						45268.56
Crisis Intervention Support	15 minute	3	2441.67	6.18	45268.56	
Dietician Services Total:						2980.64
Dietician Services	Session	2	52.00	28.66	2980.64	
Environmental Modifications Total:						4646.24

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Environmental Modifications (New)	event	2	1.00	2073.12	4146.24	
Environmental Modifications (Repair)	event	1	1.00	500.00	500.00	
Self-Directed Goods and Services Total:						0.00
Self-Directed Goods and Services	event	0	0.00	10658.00	0.00	
Skilled Nursing Total:						262608.70
Skilled Nursing	15 minute	39	271.80	18.01	190909.60	
Self Directed	Self Directed	6	1.00	11949.85	71699.10	
Specialized Equipment Total:						6519.88
Specialized Equipment (Repair)	event	2	1.00	362.00	724.00	
Specialized Equipment (New)	event	6	1.00	382.65	2295.90	
Self Directed	Self Directed	6	1.00	583.33	3499.98	
Transportation Total:						0.00
Companion Services	event	0	0.00	0.56	0.00	
Self Directed	Self Directed	0	0.00	1.00	0.00	
				GRAND TOTAL:		8677987.15
				Total Estimated Unduplicated Participants:		240
				Factor D (Divide total by number of participants):		36158.28
				Average Length of Stay on the Waiver:		260

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 3

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Services Total:						577650.00
Basic Level	15 minute	92	1250.00	2.79	320850.00	
Intermediate Level	15 minute	32	1250.00	3.63	145200.00	
High Level	15 minute	16	1250.00	5.58	111600.00	
Case Management Total:						503481.64
case management (monthly)	month	160	11.00	277.73	488804.80	
subsequent assessments	event	18	1.00	815.38	14676.84	
Community Integration Services Total:						632472.90

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Community Integration Services (Basic)	15 minute	55	909.10	3.07	153501.54	
day habilitation (daily) ending year 1	daily	0	0.00	0.01	0.00	
day habilitation intervention ending year 1	15 minute	0	0.00	0.01	0.00	
Community Integration Services (Intermediate)	15 minute	10	2000.00	3.99	79800.00	
Community Integration Services (High Level of Care)	15 minute	5	2000.00	6.14	61400.00	
day habilitation (High) ending year 1	Daily	0	0.00	0.10	0.00	
day habilitation (Intensive) ending year 1	Daily	0	0.00	0.10	0.00	
day habilitation (Intermittent) ending year 1	Daily	0	0.00	0.10	0.00	
day habilitation (Moderate) ending year 1	Daily	0	0.00	0.10	0.00	
Self Directed Day Habilitation	Self Directed	4	1.00	84442.84	337771.36	
Homemaker Total:						103682.07
Homemaker	15 minute	9	566.00	3.98	20274.12	
Self Directed	Self Directed	9	1.00	9267.55	83407.95	
Personal Care Total:						323470.89
Personal Care	15 minute	11	1207.77	3.98	52876.17	
Self Directed	Self Directed	11	1.00	24599.52	270594.72	
Prevocational Services Total:						150719.93
Prevocational (Basic Level)	15 minute	5	2000.00	2.79	27900.00	
Prevocational (Intermediate Level)	15 minute	11	1818.18	3.63	72599.93	
Prevocational (High Level)	15 minute	4	2250.00	5.58	50220.00	
Residential Habilitation Total:						3579804.56
Residential Habilitation (level 5)	daily	20	344.15	193.58	1332411.14	
Residential Habilitation (Level 6)	15 minute	6	243.33	334.27	488027.51	
Residential Habilitation (Level 4)	Daily	17	313.88	146.69	782731.97	
Residential Habilitation (Level 3)	Daily	21	323.24	123.25	836625.93	
Residential Habilitation (Level 2)	Daily	2	400.00	91.70	73360.00	
Residential Habilitation (Level 1)	Daily	2	400.00	83.31	66648.00	
Intervention	15 minute	0	0.00	6.38	0.00	

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Respite Total:						**132730.59**
Respite Daily	daily	1	20.00	190.15	**3803.00**	
Respite - 15 minute	15 minute	8	1856.13	3.61	**53605.03**	
Self Directed	Self Directed	2	1.00	37661.28	**75322.56**	
Supported Employment Total:						**238279.33**
Individual Supported Employment	15 minute	15	533.33	7.00	**55999.65**	
Group Supported Employment	15 minute	10	1800.00	2.79	**50220.00**	
follow along	15 minute	2	4500.00	7.00	**63000.00**	
Employment Discovery and Customization	15 minute	8	1125.00	6.71	**60390.00**	
Self Directed	Self Directed	2	1.00	4334.84	**8669.68**	
Supported Living Total:						**1416748.70**
Supported Living (group of 2 to 3 - 15 minute)	15 minute	5	4500.00	3.27	**73575.00**	
Supported Living (group daily)	day	8	234.50	91.69	**172010.44**	
Supported Living (individual 15 minute)	15 minute	73	1570.50	8.54	**979081.11**	
Self Directed	Self Directed	13	1.00	14775.55	**192082.15**	
Occupational Therapy Total:						**27704.32**
Occupational/Physical Therapy group	Session	2	25.00	16.49	**824.50**	
Occupational Therapy individual	15 minute	4	382.25	17.58	**26879.82**	
Physical Therapy Total:						**30407.76**
Physical Therapy (individual)	15 minute	6	235.50	21.52	**30407.76**	
Speech, Hearing and Language Services Total:						**38023.84**
Speech Hearing and Language Services (Individual)	Session	6	101.00	52.00	**31512.00**	
Speech Hearing and Language Services (Group)	Session	2	100.00	19.96	**3992.00**	
Self Directed	Self Directed	8	1.00	314.98	**2519.84**	
Independent Support Broker Total:						**202732.56**
Independent Support Broker	15 minute	12	117.08	9.75	**13698.36**	
Self Directed	Self Directed	12	1.00	15752.85	**189034.20**	
Behavioral Support Services Total:						**500.00**
Behavioral Support Services	event	1	1.00	500.00	**500.00**	

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Cognitive Retraining Total:						**32043.60**
Cognitive Retraining	15 minute	3	1290.00	8.28	**32043.60**	
Companion Services Total:						**613018.72**
Companion Services	15 minute	70	1730.93	3.98	**482237.10**	
Companion Services (group)	15 minute	1	576.00	1.99	**1146.24**	
Self Directed	Self Directed	7	1.00	18519.34	**129635.38**	
Crisis Intervention Support Total:						**31900.06**
Crisis Intervention Support	15 minute	3	1666.67	6.38	**31900.06**	
Dietician Services Total:						**3079.44**
Dietician Services	Session	2	52.00	29.61	**3079.44**	
Environmental Modifications Total:						**4646.24**
Environmental Modifications (New)	event	2	1.00	2073.12	**4146.24**	
Environmental Modifications (Repair)	event	1	1.00	500.00	**500.00**	
Self-Directed Goods and Services Total:						**0.00**
Self-Directed Goods and Services	event	0	0.00	1.00	**0.00**	
Skilled Nursing Total:						**268855.57**
Skilled Nursing	15 minute	39	271.79	18.60	**197156.47**	
Self Directed	Self Directed	6	1.00	11949.85	**71699.10**	
Specialized Equipment Total:						**6519.88**
Specialized Equipment (Repair)	event	2	1.00	362.00	**724.00**	
Specialized Equipment (New)	event	6	1.00	382.65	**2295.90**	
Self Directed	Self Directed	6	1.00	583.33	**3499.98**	
Transportation Total:						**0.00**
Companion Services	event	0	0.00	0.56	**0.00**	
Self Directed	Self Directed	0	0.00	0.56	**0.00**	
				GRAND TOTAL:		**8918472.59**
				Total Estimated Unduplicated Participants:		**240**
				Factor D (Divide total by number of participants):		**37160.30**
				Average Length of Stay on the Waiver:		260

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 4

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Services Total:						**577650.00**
Basic Level	15 minute	92	1250.00	2.79	**320850.00**	
Intermediate Level	15 minute	32	1250.00	3.63	**145200.00**	
High Level	15 minute	16	1250.00	5.58	**111600.00**	
Case Management Total:						**503481.64**
case management (monthly)	month	160	11.00	277.73	**488804.80**	
subsequent assessments	event	18	1.00	815.38	**14676.84**	
Community Integration Services Total:						**328472.90**
Community Integration Services (Basic)	15 minute	55	909.10	3.07	**153501.54**	
day habilitation (daily) ending year 1	daily	0	0.00	0.01	**0.00**	
day habilitation intervention ending year 1	15 minute	0	0.00	0.01	**0.00**	
Community Integration Services (Intermediate)	15 minute	10	2000.00	3.99	**79800.00**	
Community Integration Services (High Level of Care)	15 minute	5	2000.00	6.14	**61400.00**	
day habilitation (High) ending year 1	Daily	0	0.00	1.00	**0.00**	
day habilitation (Intensive) ending year 1	Daily	0	0.00	1.00	**0.00**	
day habilitation (Intermittent) ending year 1	Daily	0	0.00	1.00	**0.00**	
day habilitation (Moderate) ending year 1	Daily	0	0.00	1.00	**0.00**	
Self Directed Day Habilitation	Self Directed	4	1.00	8442.84	**33771.36**	
Homemaker Total:						**103019.85**
Homemaker	15 minute	9	566.00	3.85	**19611.90**	
Self Directed	Self Directed	9	1.00	9267.55	**83407.95**	
Personal Care Total:						**336597.42**
Personal Care	15 minute	11	1507.73	3.98	**66008.42**	
Self Directed	Self Directed	11	1.00	24599.00	**270589.00**	
Prevocational Services Total:						**150719.93**
Prevocational (Basic Level)	15 minute	5	2000.00	2.79	**27900.00**	
Prevocational (Intermediate Level)	15 minute	11	1818.18	3.63	**72599.93**	

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Prevocational (High Level)	15 minute	4	2250.00	5.58	50220.00	
Residential Habilitation Total:						3579804.56
Residential Habilitation (level 5)	day	20	344.15	193.58	1332411.14	
Residential Habilitation (Level 6)	15 minute	6	243.33	334.27	488027.51	
Residential Habilitation (Level 4)	Daily	17	313.88	146.69	782731.97	
Residential Habilitation (Level 3)	Daily	21	323.24	123.25	836625.93	
Residential Habilitation (Level 2)	Daily	2	400.00	91.70	73360.00	
Residential Habilitation (Level 1)	Daily	2	400.00	83.31	66648.00	
Intervention	15 minute	0	0.00	6.38	0.00	
Respite Total:						132730.59
Respite Daily	daily	1	20.00	190.15	3803.00	
Respite - 15 minute	15 minute	8	1856.13	3.61	53605.03	
Self Directed	Self Directed	2	1.00	37661.28	75322.56	
Supported Employment Total:						238279.33
Individual Supported Employment	15 minute	15	533.33	7.00	55999.65	
Group Supported Employment	15 minute	10	1800.00	2.79	50220.00	
follow along	15 minute	2	4500.00	7.00	63000.00	
Employment Discovery and Customization	15 minute	8	1125.00	6.71	60390.00	
Self Directed	Self Directed	2	1.00	4334.84	8669.68	
Supported Living Total:						1416754.93
Supported Living (group of 2 to 3 - 15 minute)	15 minute	5	4500.00	3.27	73575.00	
Supported Living (group daily)	day	8	234.50	91.69	172010.44	
Supported Living (individual 15 minute)	15 minute	73	1570.51	8.54	979087.34	
Self Directed	Self Directed	13	1.00	14775.55	192082.15	
Occupational Therapy Total:						27704.32
Occupational/Physical Therapy group	Session	2	25.00	16.49	824.50	
Occupational Therapy individual	15 minute	4	382.25	17.58	26879.82	
Physical Therapy Total:						30407.76

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Physical Therapy (individual)	15 minute	6	235.50	21.52	30407.76	
Speech, Hearing and Language Services Total:						38004.00
Speech Hearing and Language Services (Individual)	Session	6	101.00	52.00	31512.00	
Speech Hearing and Language Services (Group)	Session	2	100.00	19.96	3992.00	
Self Directed	Self Directed	8	1.00	312.50	2500.00	
Independent Support Broker Total:						202297.02
Independent Support Broker	15 minute	12	117.08	9.44	13262.82	
Self Directed	Self Directed	12	1.00	15752.85	189034.20	
Behavioral Support Services Total:						500.00
Behavioral Support Services	event	1	1.00	500.00	500.00	
Cognitive Retraining Total:						32043.60
Cognitive Retraining	15 minute	3	1290.00	8.28	32043.60	
Companion Services Total:						885461.94
Companion Services	15 minute	70	1730.93	3.98	482237.10	
Companion Services (group)	15 minute	1	576.00	1.99	1146.24	
Self Directed	Self Directed	20	1.00	20103.93	402078.60	
Crisis Intervention Support Total:						31900.06
Crisis Intervention Support	15 minute	3	1666.67	6.38	31900.06	
Dietician Services Total:						3079.44
Dietician Services	session	2	52.00	29.61	3079.44	
Environmental Modifications Total:						4646.24
Environmental Modifications (New)	event	2	1.00	2073.12	4146.24	
Environmental Modifications (Repair)	event	1	1.00	500.00	500.00	
Self-Directed Goods and Services Total:						0.00
Self-Directed Goods and Services	event	0	0.00	1424.00	0.00	
Skilled Nursing Total:						268855.81
Skilled Nursing	15 minute	39	271.79	18.60	197156.47	
Self Directed	Self Directed	6	1.00	11949.89	71699.34	
Specialized Equipment Total:						6519.88
Specialized Equipment (Repair)	event	2	1.00	362.00	724.00	

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Specialized Equipment (New)	event	6	1.00	382.65	2295.90	
Self Directed	Self Directed	6	1.00	583.33	3499.98	
Transportation Total:						0.00
Companion Services	event	0	0.00	0.56	0.00	
Self Directed	Self Directed	0	0.00	0.56	0.00	
				GRAND TOTAL:		8898931.22
				Total Estimated Unduplicated Participants:		240
				Factor D (Divide total by number of participants):		37078.88
				Average Length of Stay on the Waiver:		260

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 5

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Services Total:						577650.00
Basic Level	15 minute	92	1250.00	2.79	320850.00	
Intermediate Level	15 minute	32	1250.00	3.63	145200.00	
High Level	15 minute	16	1250.00	5.58	111600.00	
Case Management Total:						503481.64
case management (monthly)	month	160	11.00	277.73	488804.80	
subsequent assessments	event	18	1.00	815.38	14676.84	
Community Integration Services Total:						328472.93
Community Integration Services (Basic)	15 minute	55	909.10	3.07	153501.54	
day habilitation (daily) ending year 1	daily	0	0.00	3.86	0.00	
day habilitation intervention ending year 1	15 minute	0	0.00	0.01	0.00	
Community Integration Services (Intermediate)	15 minute	10	2000.00	3.99	79800.00	
Community Integration Services (High Level of Care)	15 minute	5	2000.00	6.14	61400.00	
day habilitation (High) ending year 1	Daily	0	0.00	1.00	0.00	
day habilitation (Intensive) ending year 1	Daily	0	0.00	0.10	0.00	
day habilitation (Intermittent) ending year 1	Daily	0	0.00	0.10	0.00	

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
day habilitation (Moderate) ending year 1	Daily	0	0.00	0.10	0.00	
Self Directed Day Habilitation	Self Directed	4	1.00	8442.85	33771.40	
Homemaker Total:						103682.07
Homemaker	15 minute	9	566.00	3.98	20274.12	
Self Directed	Self Directed	9	1.00	9267.55	83407.95	
Personal Care Total:						336603.14
Personal Care	15 minute	11	1507.73	3.98	66008.42	
Self Directed	Self Directed	11	1.00	24599.52	270594.72	
Prevocational Services Total:						150719.93
Prevocational (Basic Level)	15 minute	5	2000.00	2.79	27900.00	
Prevocational (Intermediate Level)	15 minute	11	1818.18	3.63	72599.93	
Prevocational (High Level)	15 minute	4	2250.00	5.58	50220.00	
Residential Habilitation Total:						3579804.56
Residential Habilitation (level 5)	daily	20	344.15	193.58	1332411.14	
Residential Habilitation (Level 6)	15 minute	6	243.33	334.27	488027.51	
Residential Habilitation (Level 4)	Daily	17	313.88	146.69	782731.97	
Residential Habilitation (Level 3)	Daily	21	323.24	123.25	836625.93	
Residential Habilitation (Level 2)	Daily	2	400.00	91.70	73360.00	
Residential Habilitation (Level 1)	Daily	2	400.00	83.31	66648.00	
Intervention	15 minute	0	0.00	6.38	0.00	
Respite Total:						132730.59
Respite Daily	daily	1	20.00	190.15	3803.00	
Respite - 15 minute	15 minute	8	1856.13	3.61	53605.03	
Self Directed	Self Directed	2	1.00	37661.28	75322.56	
Supported Employment Total:						238279.33
Individual Supported Employment	15 minute	15	533.33	7.00	55999.65	
Group Supported Employment	15 minute	10	1800.00	2.79	50220.00	
follow along	15 minute	2	4500.00	7.00	63000.00	

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Employment Discovery and Customization	15 minute	8	1125.00	6.71	60390.00	
Self Directed	Self Directed	2	1.00	4334.84	8669.68	
Supported Living Total:						1416748.70
Supported Living (group of 2 to 3 - 15 minute)	15 minute	5	4500.00	3.27	73575.00	
Supported Living (group daily)	day	8	234.50	91.69	172010.44	
Supported Living (individual 15 minute)	15 minute	73	1570.50	8.54	979081.11	
Self Directed	Self Directed	13	1.00	14775.55	192082.15	
Occupational Therapy Total:						40625.62
Occupational/Physical Therapy group	session	2	25.00	16.49	824.50	
Occupational Therapy individual	15 minute	4	566.00	17.58	39801.12	
Physical Therapy Total:						30407.76
Physical Therapy (individual)	session	6	235.50	21.52	30407.76	
Speech, Hearing and Language Services Total:						38004.00
Speech Hearing and Language Services (Individual)	session	6	101.00	52.00	31512.00	
Speech Hearing and Language Services (Group)	session	2	100.00	19.96	3992.00	
Self Directed	Self Directed	8	1.00	312.50	2500.00	
Independent Support Broker Total:						202734.80
Independent Support Broker	15 minute	12	117.10	9.75	13700.70	
Self Directed	Self Directed	10	1.00	18903.41	189034.10	
Behavioral Support Services Total:						500.00
Behavioral Support Services	event	1	1.00	500.00	500.00	
Cognitive Retraining Total:						32043.60
Cognitive Retraining	15 minute	3	1290.00	8.28	32043.60	
Companion Services Total:						885461.94
Companion Services	15 minute	70	1730.93	3.98	482237.10	
Companion Services (group)	15 minute	1	576.00	1.99	1146.24	
Self Directed	Self Directed	20	1.00	20103.93	402078.60	
Crisis Intervention Support Total:						31900.06
Crisis Intervention Support	15 minute	3	1666.67	6.38	31900.06	

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Dietician Services Total:						**3079.44**
Dietician Services	session	2	52.00	29.61	**3079.44**	
Environmental Modifications Total:						**46108.64**
Environmental Modifications (New)	event	2	11.00	2073.12	**45608.64**	
Environmental Modifications (Repair)	event	1	1.00	500.00	**500.00**	
Self-Directed Goods and Services Total:						**0.00**
Self-Directed Goods and Services	event	1	0.00	1424.00	**0.00**	
Skilled Nursing Total:						**236293.72**
Skilled Nursing	15 minute	39	271.80	18.60	**197163.72**	
Self Directed	Self Directed	2	1.00	19565.00	**39130.00**	
Specialized Equipment Total:						**6519.88**
Specialized Equipment (Repair)	event	2	1.00	362.00	**724.00**	
Specialized Equipment (New)	event	6	1.00	382.65	**2295.90**	
Self Directed	Self Directed	6	1.00	583.33	**3499.98**	
Transportation Total:						**0.00**
Companion Services	event	0	0.00	0.56	**0.00**	
Self Directed	Self Directed	0	0.00	0.56	**0.00**	

GRAND TOTAL:	**8921852.36**
Total Estimated Unduplicated Participants:	**240**
Factor D (Divide total by number of participants):	**37174.38**
Average Length of Stay on the Waiver:	260